Senate Bill 236

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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.**

Limits discretion of Oregon Health Authority with respect to contracts with and rules concerning coordinated care organizations and imposes new requirements. Imposes requirements on authority for rulemaking and collaborating with coordinated care organizations. Imposes additional responsibilities on Oregon Health Policy Board in oversight of authority, Health Evidence Review Commission and Office for Oregon Health Policy and Research.

Requires Department of Consumer and Business Services to certify global budget before budget may take effect.

A BILL FOR AN ACT

Relating to coordinated care organizations; creating new provisions; and amending ORS 413.011, 414.025, 414.638, 414.652, 414.688, 414.689, 414.690, 414.695, 414.735 and 442.011.

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

SECTION 1. Section 2 of this 2017 Act is added to and made a part of ORS chapter 414.

SECTION 2. (1) The Oregon Health Authority shall:

(a) Oversee coordinated care organizations' compliance with statutory and regulatory requirements for the expenditure of funds provided under Title XIX and Title XXI of the Social Security Act.

(b) Collect from each coordinated care organization and submit to the Centers for Medicare and Medicaid Services any data required to be reported by coordinated care organizations.

(c) Provide all coordinated care organizations with equal and uniform access to:

(A) Information;

(B) Opportunities to comment on proposed policies or rules, or to meet and discuss policy or rules; and

(C) Opportunities to participate in advisory committees.

(2) The authority shall invite a representative from each coordinated care organization to participate in any advisory committee responsible for making recommendations regarding the services that must be provided by coordinated care organizations, and any meeting of such advisory committee shall be open to the public and invite public comment.

(3)(a) Rules adopted by the authority must be strictly tailored to the requirements of state statutes and federal law.

(b) The authority may not adopt rules that apply to a period that begins less than 30 days after the date the rule is filed with the Secretary of State.

(c) The authority shall appoint an advisory committee under ORS 183.333 with respect to the development of any rule that affects a coordinated care organization and shall invite a

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.

representative from each coordinated care organization to serve on the committee.

(d) Upon filing a final rule with the Secretary of State, the authority shall publish notice of the rule on its website along with summaries of comments received during the comment period for the rule and the authority's responses to the comments.

(e) The statement of fiscal impact required by ORS 183.335 must include a description of all alternatives for implementing the policy that were considered by the authority that would be less costly to coordinated care organizations and the authority's justification for not adopting a less costly alternative.

(4) The authority may not require a coordinated care organization to provide health services to medical assistance recipients whose assistance is reimbursed on a fee-for-service basis.

(5) The authority shall adopt health outcome and quality measures approved by the Oregon Health Policy Board under ORS 413.017 (4) but may not prescribe for coordinated care organizations how to achieve the measures.

(6) The authority shall apply to the Centers for Medicare and Medicaid Services to amend the terms and conditions of the Medicaid demonstration project to conform to legislative changes enacted during a session of the Legislative Assembly immediately upon adjournment sine die of the Legislative Assembly.

SECTION 3. (1) As used in this section, "global budget" has the meaning given that term in ORS 414.025.

(2) The Department of Consumer and Business Services must certify each global budget established by the Oregon Health Authority before the global budget may take effect.

(3) The department may certify a global budget only if the department determines that the global budget:

(a) Meets the requirements of ORS 414.065 (5); and

(b) Is based on sound data, assumptions and methodologies uniformly applied to all coordinated care organizations.

(4) The department shall consider:

(a) All information provided by the Oregon Health Authority;

(b) Comments provided to the authority by a coordinated care organization under ORS 414.652 (4)(b); and

(c) Other information that the department deems relevant.

SECTION 4. ORS 413.011, as amended by section 6, chapter 389, Oregon Laws 2015, 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) 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 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.

(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.

(o) Work with the Health Information Technology Oversight Council to foster health information technology systems and practices that promote the Oregon Integrated and Coordinated Health Care Delivery System established by ORS 414.620 and align health information technology systems and practices across this state.

(p) Provide independent oversight of the authority's compliance with federal and state requirements for the administration of the medical assistance program and for contracting

with coordinated care organizations.

(q) Ensure that coordinated care organizations are reporting to the authority and that the authority is compiling all required data including, but not limited to, data concerning the compliance of coordinated care organizations with the quality performance benchmarks established under paragraph (d) of this subsection.

(r)(A) Investigate complaints or concerns expressed with respect to a coordinated care organization's compliance with requirements adopted by rule under ORS 414.625;

(B) Report the results of the investigation to the Director of the Oregon Health Authority along with a plan for corrective actions; and

(C) Require the director to regularly report to the board on the progress made in achieving the corrective actions.

(s) Approve proposed legislative measures before they may be submitted to the Governor for approval under ORS 171.133.

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

(a) Appoint all subordinate officers and employees of the board, prescribe their duties and fix their compensation.

(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 5. ORS 414.025, as amended by section 9, chapter 389, Oregon Laws 2015, is amended to read:

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

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

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

(A) Shared savings arrangements;

(B) Bundled payments; and

(C) Payments based on episodes.

(2) "Behavioral health clinician" means:

(a) A licensed psychiatrist;

(b) A licensed psychologist;

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

(d) A licensed clinical social worker;

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

(f) A certified clinical social work associate;

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

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

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

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

(5) "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.

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

(7) "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.

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

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

(10) "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 Evi-

dence 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.

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

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

(A) Mental illness.

(B) Substance use disorders.

(C) Health behaviors that contribute to chronic illness.

(D) Life stressors and crises.

(E) Developmental risks and conditions.

(F) Stress-related physical symptoms.

(G) Preventive care.

(H) Ineffective patterns of health care utilization.

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

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

(B) Peer wellness specialists;

(C) Peer support specialists;

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

(E) Personal health navigators; or

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

(13) "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.

(14) "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.

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

(16) "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.

(17) "Peer support specialist" means any of the following individuals who provide supportive services to a current or former consumer of mental health or addiction treatment:

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

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

(c) A family member of a current or former consumer of mental health or addiction treatment.

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

(19) "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.

(20) "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.

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

(22) "Quality measure" means the health outcome and quality measures and benchmarks identi-

fied by the Health Plan Quality Metrics Committee and the metrics and scoring subcommittee in accordance with ORS 413.017 (4) and 414.638.

(23) "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 6. ORS 414.638, as amended by section 10, chapter 389, Oregon Laws 2015, is amended to read:

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

(a) Three members at large;

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

(c) Three representatives of coordinated care organizations.

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

(3) The subcommittee shall evaluate the health outcome and quality measures 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 **health** 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 **health** outcome and quality measures selected by the subcommittee under this section for members in each coordinated care organization and for members statewide.

(5) The authority shall make the health outcome and quality measures available to the coordinated care organizations no later than October 1 of the year prior to the year in which the measures are to be in effect.

SECTION 7. ORS 414.652, as amended by section 1, chapter 79, Oregon Laws 2016, is amended to read:

414.652. (1) A contract entered into between the Oregon Health Authority and a coordinated care organization under ORS 414.625 (1) **shall provide the coordinated care organization with maximum flexibility in the delivery of health services subject only to those requirements specified by state statutes or federal law and**:

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

(b) Except as provided in subsection (3) of this section, may not be amended more than once in each 12-month period; and

(c) May be terminated if a coordinated care organization fails to meet outcome and quality

measures specified in the contract or is otherwise in breach of the contract.

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

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

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

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

(4)**(a) Except as provided in paragraph (b) of this subsection,** the authority [*must*] **shall** give a coordinated care organization at least 60 days' advance notice of any amendments the authority proposes to existing contracts between the authority and the coordinated care organization, or to contracts to be renewed[*, including the global budget paid to the coordinated care organization under the contract*].

(b) The authority shall give a coordinated care organization notice of an amendment to the global budget paid to the coordinated care organization under the contract at least 30 days before submitting the amendment to the Department of Consumer and Business Services for certification under section 3 of this 2017 Act.

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

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

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

SECTION 8. ORS 414.688 is amended to read:

414.688. (1) As used in this section:

(a) "Practice of pharmacy" has the meaning given that term in ORS 689.005.

(b) "Retail drug outlet" has the meaning given that term in ORS 689.005.

(2) The Health Evidence Review Commission is established [*in the Oregon Health Authority*] **under the supervision and oversight of the Oregon Health Policy Board**, consisting of 13 members appointed by the Governor in consultation with professional and other interested organizations, and confirmed by the Senate, as follows:

(a) Five members must be physicians licensed to practice medicine in this state who have clinical expertise in the areas of family medicine, internal medicine, obstetrics, perinatal health, pediatrics, disabilities, geriatrics or general surgery. One of the physicians must be a doctor of osteopathy, and one must be a hospital representative or a physician whose practice is significantly hospital-based.

(b) One member must be a dentist licensed under ORS chapter 679 who has clinical expertise in general, pediatric or public health dentistry.

(c) One member must be a public health nurse.

(d) One member must be a behavioral health representative who may be a social services worker, alcohol and drug treatment provider, psychologist or psychiatrist.

(e) Two members must be consumers of health care who are patient advocates or represent the areas of indigent services, labor, business, education or corrections.

(f) One member must be a complementary or alternative medicine provider who is a chiropractic

physician licensed under ORS chapter 684, a naturopathic physician licensed under ORS chapter 685 or an acupuncturist licensed under ORS chapter 677.

(g) One member must be an insurance industry representative who may be a medical director or other administrator.

(h) One member must be a pharmacy representative who engages in the practice of pharmacy at a retail drug outlet.

(3) No more than six members of the commission may be physicians either in active practice or retired from practice.

(4) Members of the commission serve for a term of four years at the pleasure of the Governor. A member is eligible for reappointment.

(5) Members are not entitled to compensation, but may be reimbursed for actual and necessary travel and other expenses incurred by them in the performance of their official duties in the manner and amounts provided for in ORS 292.495. Claims for expenses shall be paid out of funds available to the Oregon Health [*Authority*] **Policy Board** for purposes of the commission.

SECTION 9. ORS 414.689 is amended to read:

414.689. (1) The Health Evidence Review Commission shall select one of its members as chairperson and another as vice chairperson, for terms and with duties and powers the commission determines necessary for the performance of the functions of the offices.

(2) A majority of the members of the commission constitutes a quorum for the transaction of business.

(3) The commission shall meet at least four times per year at a place, day and hour determined by the chairperson. The commission also shall meet at other times and places specified by the call of the chairperson or of a majority of the members of the commission.

(4) The commission may use advisory committees or subcommittees whose members are appointed by the chairperson of the commission subject to approval by a majority of the members of the commission. The advisory committees or subcommittees may contain experts appointed by the chairperson and a majority of the members of the commission. The conditions of service of the experts will be determined by the chairperson and a majority of the members of the commission.

(5) The Oregon Health [*Authority*] **Policy Board** shall provide staff and support services to the commission.

SECTION 10. ORS 414.690 is amended to read:

414.690. (1) The Health Evidence Review Commission shall regularly solicit testimony and information from stakeholders representing consumers, advocates, providers, carriers and employers in conducting the work of the commission.

(2) The commission shall actively solicit public involvement through a public meeting process to guide health resource allocation decisions.

(3) The commission shall develop and maintain a list of health services ranked by priority, from the most important to the least important, representing the comparative benefits of each service to the population to be served. The list must be submitted by the commission pursuant to subsection (5) of this section and is not subject to alteration by any other state agency.

(4) In order to encourage effective and efficient medical evaluation and treatment, the commission:

(a) May include clinical practice guidelines in its prioritized list of services. The commission shall actively solicit testimony and information from the medical community and the public to build a consensus on clinical practice guidelines developed by the commission.

(b) May include statements of intent in its prioritized list of services. Statements of intent should give direction on coverage decisions where medical codes and clinical practice guidelines cannot convey the intent of the commission.

(c) Shall consider both the clinical effectiveness and cost-effectiveness of health services, including drug therapies, in determining their relative importance using peer-reviewed medical literature as defined in ORS 743A.060.

(5) The commission shall report the prioritized list of services to the Oregon Health [*Authority*] **Policy Board** for budget determinations by July 1 of each even-numbered year.

(6) The commission shall make its report during each regular session of the Legislative Assembly and shall submit a copy of its report to the Governor, the Speaker of the House of Representatives and the President of the Senate.

(7) The commission may alter the list during the interim only as follows:

(a) To make technical changes to correct errors and omissions;

(b) To accommodate changes due to advancements in medical technology or new data regarding health outcomes;

(c) To accommodate changes to clinical practice guidelines; and

(d) To add statements of intent that clarify the prioritized list.

(8) If a service is deleted or added during an interim and no new funding is required, the commission shall report to the Speaker of the House of Representatives and the President of the Senate. However, if a service to be added requires increased funding to avoid discontinuing another service, the commission shall report to the Emergency Board to request the funding.

(9) The prioritized list of services remains in effect for a two-year period beginning no earlier than October 1 of each odd-numbered year.

SECTION 11. ORS 414.695 is amended to read:

414.695. (1) As used in this section and ORS 414.698:

(a) "Medical technology" means medical equipment and devices, medical or surgical procedures and techniques used by health care providers in delivering medical care to individuals, and the organizational or supportive systems within which medical care is delivered.

(b) "Medical technology assessment" means evaluation of the use, clinical effectiveness and cost of a technology in comparison with its alternatives.

(2) The Health Evidence Review Commission shall develop a medical technology assessment process. The Oregon Health [*Authority*] **Policy Board** shall direct the commission with regard to medical technologies to be assessed and the timing of the assessments.

(3) The commission shall appoint and work with an advisory committee whose members have the appropriate expertise to conduct a medical technology assessment.

(4) The commission shall present its preliminary findings at a public hearing and shall solicit testimony and information from health care consumers. The commission shall give strong consideration to the recommendations of the advisory committee and public testimony in developing its assessment.

(5) To ensure that confidentiality is maintained, identification of a patient or a person licensed to provide health services may not be included with the data submitted under this section, and the commission shall release such data only in aggregate statistical form. All findings and conclusions, interviews, reports, studies, communications and statements procured by or furnished to the commission in connection with obtaining the data necessary to perform its functions is confidential pursuant to ORS 192.501 to 192.505.

SECTION 12. ORS 414.735 is amended to read:

414.735. (1) If insufficient resources are available during a contract period:

(a) The population of eligible persons determined by law may not be reduced.

(b) The reimbursement rate for providers and plans established under the contractual agreement may not be reduced.

(2) In the circumstances described in subsection (1) of this section, reimbursement shall be adjusted by reducing the health services for the eligible population by eliminating services in the order of priority recommended by the Health Evidence Review Commission, starting with the least important and progressing toward the most important.

(3) The Oregon Health [*Authority*] **Policy Board** shall obtain the approval of the Legislative Assembly, or the Emergency Board if the Legislative Assembly is not in session, before instituting the reductions. In addition, providers contracting to provide health services under [*ORS 414.631, 414.651 and 414.688 to 414.745*] **this chapter** must be notified at least two weeks prior to any legislative consideration of such reductions. Any reductions made under this section shall take effect no sooner than 60 days following final legislative action approving the reductions.

(4) This section does not apply to reductions made by the Legislative Assembly in a legislatively adopted or approved budget.

SECTION 13. ORS 442.011 is amended to read:

442.011. There is created in the Oregon Health [*Authority*] **Policy Board** the Office for Oregon Health Policy and Research. The Administrator of the Office for Oregon Health Policy and Research shall be appointed by the [*Director of the Oregon Health Authority*] **chairperson of the board**. The administrator shall be an individual with demonstrated proficiency in planning and managing programs with complex public policy and fiscal aspects such as those involved in the medical assistance program.

SECTION 14. Section 3 of this 2017 Act applies to global budgets in effect on and after January 1, 2018.