SB 934-3
(LC 1658)
4/14/17 (LHF/ps)

Requested by Senator STEINER HAYWARD

PROPOSED AMENDMENTS TO
SENATE BILL 934

On page 1 of the printed bill, line 2, after "ORS" insert "243.105, 243.135, 243.860, 243.866,".

In line 3, after "743.010" insert "and sections 1, 2 and 5, chapter 575, Oregon Laws 2015".

Delete lines 5 through 30 and delete pages 2 through 8 and insert:

"**SECTION 1.** ORS 414.625 is amended to read:

"414.625. (1) The Oregon Health Authority shall adopt by rule the qualification criteria and requirements for a coordinated care organization and shall integrate the criteria and requirements into each contract with a coordinated care organization. Coordinated care organizations may be local, community-based organizations or statewide organizations with community-based participation in governance or any combination of the two. Coordinated care organizations may contract with counties or with other public or private entities to provide services to members. The authority may not contract with only one statewide organization. A coordinated care organization may be a single corporate structure or a network of providers organized through contractual relationships. The criteria adopted by the authority under this section must include, but are not limited to, the coordinated care organization's demonstrated experience and capacity for:

"(a) Managing financial risk and establishing financial reserves.

"(b) Meeting the following minimum financial requirements:

"(A) Maintaining restricted reserves of $250,000 plus an amount equal to 50 percent of the coordinated care organization's total actual or projected liabilities above $250,000.

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

"(c) Operating within a fixed global budget **and:**

"(A) By January 1, 2023, spending at least 12 percent of the global budget on primary care, as defined in section 2, chapter 575, Oregon Laws 2015; or

"(B) Participating in a national primary care medical home payment model, conducted by the Center for Medicare and Medicaid Innovation in accordance with 42 U.S.C. 1315a, that includes performance-based incentive payments for primary care.

"(d) Developing and implementing alternative payment methodologies that are based on health care quality and improved health outcomes.

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

"(f) Engaging community members and health care providers in improving the health of the community and addressing regional, cultural, socioeconomic and racial disparities in health care that exist among the coordinated care organization's members and in the coordinated care organization's community.

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

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

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

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

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

"(e) Members receive assistance in navigating the health care delivery system and in accessing community and social support services and statewide resources, including through the use of certified health care interpreters, as defined in ORS 413.550, community health workers and personal health navigators who meet competency standards established by the authority under ORS 414.665 or who are certified by the Home Care Commission under ORS 410.604.

"(f) Services and supports are geographically located as close to where members reside as possible and are, if available, offered in nontraditional settings that are accessible to families, diverse communities and underserved populations.

"(g) Each coordinated care organization uses health information technology to link services and care providers across the continuum of care to the greatest extent practicable and if financially viable.

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

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

"(j) Each coordinated care organization prioritizes working with members who have high health care needs, multiple chronic conditions, mental illness

or chemical dependency and involves those members in accessing and managing appropriate preventive, health, remedial and supportive care and services to reduce the use of avoidable emergency room visits and hospital admissions.

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

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

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

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

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

"(E) Include providers of specialty care.

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

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

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

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

"(n) Each coordinated care organization participates in the learning

collaborative described in ORS 413.259 (3).

"(o) Each coordinated care organization has a governing body that includes:

"(A) Persons that share in the financial risk of the organization who must constitute a majority of the governing body;

"(B) The major components of the health care delivery system;

"(C) At least two health care providers in active practice, including:

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

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

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

"(E) At least one member of the community advisory council.

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

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

"(4) In selecting one or more coordinated care organizations to serve a geographic area, the authority shall:

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

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

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

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

"SECTION 2. Section 3 of this 2017 Act is added to and made a part of ORS chapter 413.

"SECTION 3. (1) As used in this section, 'primary care' has the meaning given that term in section 2, chapter 575, Oregon Laws 2015.

"(2) A coordinated care organization that spends less than 12 percent of its global budget on primary care shall submit to the Oregon Health Authority a plan to increase spending on primary care as a percentage of its global budget by at least one percent each year.

"SECTION 4. ORS 414.653 is amended to read:

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

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

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

"(c) Reward good performance;

"(d) Limit increases in medical costs; and

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

"(A) Promote prevention;

"(B) Provide person centered care; and

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

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

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

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

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

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

"(b) Reimbursed by a coordinated care organization.

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

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

"(c) The authority shall identify any rural hospital that would not be expected to remain financially viable if paid in a manner other than as prescribed in paragraphs (a) and (b) of this subsection based upon an evaluation by an actuary retained by the authority. On and after July 1, 2014, the au-

thority may, on a case-by-case basis, require a coordinated care organization to continue to reimburse a rural hospital determined to be at financial risk, in the manner prescribed in paragraphs (a) and (b) of this subsection.

"(d) This subsection does not prohibit a coordinated care organization and a hospital from mutually agreeing to reimbursement other than the reimbursement specified in paragraph (a) of this subsection.

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

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

"SECTION 5. ORS 743.010 is amended to read:

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

"[*(1)*] **(a)** Establishing minimum benefit standards;

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

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

"(d) Establishing requirements for carriers offering health benefit plans that spend less than 12 percent of premiums on payments for primary care to submit with each rate filing a plan to increase spending on payments for primary care as a percentage of premiums by at least one percent each plan year.

"(2) As used in this section, 'primary care' means family medicine,

general internal medicine, naturopathic medicine, obstetrics and gynecology, pediatrics, general psychiatry or services provided by a national primary care medical home payment model, conducted by the Center for Medicare and Medicaid Innovation in accordance with 42 U.S.C. 1315a.

"SECTION 6. Section 7 of this 2017 Act is added to and made a part of the Insurance Code.

"SECTION 7. An insurer offering a health benefit plan, as defined in ORS 743B.005, that reimburses the costs of services provided by a national primary care medical home payment model, conducted by the Center for Medicare and Medicaid Innovation in accordance with 42 U.S.C. 1315a, that includes performance-based incentive payments for primary care, shall offer similar alternative payment methodologies to reimburse the costs of services provided by patient centered primary care homes identified in accordance with ORS 413.259 that serve beneficiaries of the health benefit plan.

"SECTION 8. ORS 243.105 is amended to read:

"243.105. As used in ORS 243.105 to 243.285, unless the context requires otherwise:

"(1) 'Benefit plan' includes, but is not limited to:

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

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

"(c) Self-insurance programs managed by the Public Employees' Benefit Board.

"(2) 'Board' means the Public Employees' Benefit Board.

"(3) 'Carrier' means an insurance company or health care service contractor holding a valid certificate of authority from the Director of the De-

partment of Consumer and Business Services, or two or more companies or contractors acting together pursuant to a joint venture, partnership or other joint means of operation, or a board-approved guarantor of benefit plan coverage and compensation.

"(4)(a) 'Eligible employee' means an officer or employee of a state agency or local government who elects to participate in one of the group benefit plans described in ORS 243.135. The term includes, but is not limited to, state officers and employees in the exempt, unclassified and classified service, and state officers and employees, whether or not retired, who:

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

"(B) Are eligible to receive a service retirement allowance under the Public Employees Retirement System and have reached earliest retirement age under ORS chapter 238;

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

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

"(b) 'Eligible employee' does not include individuals:

"(A) Engaged as independent contractors;

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

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

"(D) Appointed under ORS 240.309;

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

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

"(G) Who are members of a collective bargaining unit that represents police officers or firefighters.

"(5) 'Family member' means an eligible employee's spouse and any unmarried child or stepchild within age limits and other conditions imposed by the board with regard to unmarried children or stepchildren.

"(6) 'Local government' means any city, county or special district in this state or any intergovernmental entity created under ORS chapter 190.

"(7) 'Payroll disbursing officer' means the officer or official authorized to disburse moneys in payment of salaries and wages of employees of a state agency or local government.

"(8) 'Premium' means the monthly or other periodic charge for a benefit plan.

"**(9) 'Primary care' means family medicine, general internal medicine, naturopathic medicine, obstetrics and gynecology, pediatrics, general psychiatry or services provided by a national primary care medical home payment model, conducted by the Center for Medicare and Medicaid Innovation in accordance with 42 U.S.C. 1315a.**

"[*(9)*] **(10)** 'State agency' means every state officer, board, commission, department or other activity of state government.

"SECTION 9. ORS 243.135, as amended by section 4, chapter 389, Oregon Laws 2015, 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;

"(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

provider-patient relations between a particular panel of 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.

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

"(9) No later than February 1 of each year, the board shall report to the Legislative Assembly on the board's progress toward achieving the target of spending at least 12 percent of total expenditures in self-insured health benefit plans on payments for primary care.

"SECTION 10. ORS 243.860 is amended to read:

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

"(1) 'Benefit plan' includes but is not limited to:

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

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

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

"(2) 'Carrier' means an insurance company or health care service contractor holding a valid certificate of authority from the Director of the Department of Consumer and Business Services, or two or more companies or contractors acting together pursuant to a joint venture, partnership or other

joint means of operation, or a board-approved provider or guarantor of benefit plan coverage and compensation.

"(3) 'District' means a common school district, a union high school district, an education service district, as defined in ORS 334.003, or a community college district, as defined in ORS 341.005.

"(4)(a) 'Eligible employee' includes:

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

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

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

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

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

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

"(b) Except as provided in paragraph (a)(B) of this subsection, 'eligible employee' does not include an individual:

"(A) Engaged as an independent contractor;

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

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

"(5) 'Family member' means an eligible employee's spouse or domestic partner and any unmarried child or stepchild of an eligible employee within age limits and other conditions imposed by the Oregon Educators Benefit Board with regard to unmarried children or stepchildren.

"(6) 'Local government' means any city, county or special district in this state.

"(7) 'Payroll disbursing officer' means the officer or official authorized to disburse moneys in payment of salaries and wages of officers and employees of a district or a local government.

"(8) 'Premium' means the monthly or other periodic charge, including administrative fees of the Oregon Educators Benefit Board, for a benefit plan.

"**(9) 'Primary care' means family medicine, general internal medicine, naturopathic medicine, obstetrics and gynecology, pediatrics, general psychiatry or services provided by a national primary care medical home payment model, conducted by the Center for Medicare and Medicaid Innovation in accordance with 42 U.S.C. 1315a.**

"SECTION 11. ORS 243.866, as amended by section 5, chapter 389, Oregon Laws 2015, 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;

"(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 provider-patient relations between a particular panel of 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.

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

"(10) No later than February 1 of each year, the board shall report to the Legislative Assembly on the board's progress toward achieving the target of spending at least 12 percent of total expenditures on payments for primary care.

"SECTION 12. Section 1, chapter 575, Oregon Laws 2015, is amended to read:

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

"(a) 'Carrier' means an insurer that offers a health benefit plan, as defined in ORS [*743.730*] **743B.005**.

"(b) 'Prominent carrier' means:

"(A) A carrier with annual premium income at a threshold**, of no less than $50 million,** established by the Department of Consumer and Business Services by rule.

"(B) The Public Employees' Benefit Board.

"(C) The Oregon Educators Benefit Board.

"(2) All prominent carriers shall, and carriers other than prominent carriers may, report to the Department of Consumer and Business Services, no later than December 31[*, 2015*] **of each year**, the proportion of the carrier's total medical expenses that are allocated to primary care.

"(3) The department shall share with the Oregon Health Authority the information reported so that the authority may prepare the evaluation and report described in section 2**,** [*of this 2015 Act*] **chapter 575, Oregon Laws 2015**.

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

"SECTION 13. Section 2, chapter 575, Oregon Laws 2015, is amended to read:

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

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

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

"(c) 'Primary care' means family medicine, general internal medicine, naturopathic medicine, obstetrics and gynecology, pediatrics**,** [*or*] general psychiatry **or services provided by a national primary care medical home payment model, conducted by the Center for Medicare and Medicaid Innovation in accordance with 42 U.S.C. 1315a**.

"(d) 'Primary care provider' includes:

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

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

"(2)**(a)** The Oregon Health Authority shall convene a primary care payment reform collaborative to [*advise and assist the authority in developing a Primary Care Transformation Initiative to develop and share best practices in technical assistance and methods of reimbursement that direct greater health care resources and investments toward supporting and facilitating health care*

innovation and care improvement in primary care.] **advise and assist in the implementation of a Primary Care Transformation Initiative to:**

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

"(i) Increase the investment in primary care;

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

"(iii) Continue to improve reimbursement methods, including by investing in the social determinants of health;

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

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

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

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

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

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

"(3) The authority shall invite representatives from all of the following to participate in the primary care payment reform collaborative:

"(a) Primary care providers;

"(b) Health care consumers;

"(c) Experts in primary care contracting and reimbursement;

"(d) Independent practice associations;

"(e) Behavioral health treatment providers;

"(f) Third party administrators;

"(g) Employers that offer self-insured health benefit plans;

"(h) The Department of Consumer and Business Services;

"(i) Carriers;

"(j) A statewide organization for mental health professionals who provide primary care;

"(k) A statewide organization representing federally qualified health centers;

"(L) A statewide organization representing hospitals and health systems;

"(m) A statewide professional association for family physicians;

"(n) A statewide professional association for physicians;

"(o) A statewide professional association for nurses; and

"(p) The Centers for Medicare and Medicaid Services.

"(4) [*The authority shall convene the primary care payment reform collaborative no later than October 1, 2015.*] **The primary care payment reform collaborative shall annually report to the Oregon Health Policy Board and to the Legislative Assembly on the achievement of the primary care spending targets in ORS 414.625 and 743.010 and the implementation of the Primary Care Transformation Initiative.**

"(5) A coordinated care organization shall report to the authority, no later than December 31[*, 2015*] **of each year**, the proportion of the organization's total medical costs that are allocated to primary care.

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

"SECTION 14. ORS 414.625, as amended by section 1 of this 2017 Act, is amended to read:

"414.625. (1) The Oregon Health Authority shall adopt by rule the qualification criteria and requirements for a coordinated care organization and shall integrate the criteria and requirements into each contract with a coordinated care organization. Coordinated care organizations may be local, community-based organizations or statewide organizations with community-

based participation in governance or any combination of the two. Coordinated care organizations may contract with counties or with other public or private entities to provide services to members. The authority may not contract with only one statewide organization. A coordinated care organization may be a single corporate structure or a network of providers organized through contractual relationships. The criteria adopted by the authority under this section must include, but are not limited to, the coordinated care organization's demonstrated experience and capacity for:

"(a) Managing financial risk and establishing financial reserves.

"(b) Meeting the following minimum financial requirements:

"(A) Maintaining restricted reserves of $250,000 plus an amount equal to 50 percent of the coordinated care organization's total actual or projected liabilities above $250,000.

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

"(c) Operating within a fixed global budget and:

"(A) [*By January 1, 2023,*] Spending at least 12 percent of the global budget on primary care[*, as defined in section 2, chapter 575, Oregon Laws 2015*] **as defined by the authority by rule**; or

"(B) Participating in a national primary care medical home payment model, conducted by the Center for Medicare and Medicaid Innovation in accordance with 42 U.S.C. 1315a, that includes performance-based incentive payments for primary care.

"(d) Developing and implementing alternative payment methodologies that are based on health care quality and improved health outcomes.

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

"(f) Engaging community members and health care providers in improving

the health of the community and addressing regional, cultural, socioeconomic and racial disparities in health care that exist among the coordinated care organization's members and in the coordinated care organization's community.

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

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

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

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

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

"(e) Members receive assistance in navigating the health care delivery system and in accessing community and social support services and statewide resources, including through the use of certified health care interpreters, as defined in ORS 413.550, community health workers and personal health navigators who meet competency standards established by the authority under ORS 414.665 or who are certified by the Home Care Commission under ORS 410.604.

"(f) Services and supports are geographically located as close to where members reside as possible and are, if available, offered in nontraditional settings that are accessible to families, diverse communities and underserved

populations.

"(g) Each coordinated care organization uses health information technology to link services and care providers across the continuum of care to the greatest extent practicable and if financially viable.

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

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

"(j) Each coordinated care organization prioritizes working with members who have high health care needs, multiple chronic conditions, mental illness or chemical dependency and involves those members in accessing and managing appropriate preventive, health, remedial and supportive care and services to reduce the use of avoidable emergency room visits and hospital admissions.

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

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

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

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

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

"(E) Include providers of specialty care.

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

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

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

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

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

"(o) Each coordinated care organization has a governing body that includes:

"(A) Persons that share in the financial risk of the organization who must constitute a majority of the governing body;

"(B) The major components of the health care delivery system;

"(C) At least two health care providers in active practice, including:

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

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

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

"(E) At least one member of the community advisory council.

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

"(3) The authority shall consider the participation of area agencies and other nonprofit agencies in the configuration of coordinated care organiza-

tions.

"(4) In selecting one or more coordinated care organizations to serve a geographic area, the authority shall:

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

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

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

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

"SECTION 15. Section ORS 743.010, as amended by section 5 of this 2017 Act is amended to read:

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

"(a) Establishing minimum benefit standards;

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

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

"(d) Establishing requirements for carriers offering health benefit plans [*that spend less than*] **to spend at least** 12 percent of premiums on payments for primary care [*to submit with each rate filing a plan to increase spending*

on payments for primary care as a percentage of premiums by at least one percent each plan year].

"(2) As used in this section, 'primary care' means family medicine, general internal medicine, naturopathic medicine, obstetrics and gynecology, pediatrics, general psychiatry or services provided by a national primary care medical home payment model, conducted by the Center for Medicare and Medicaid Innovation in accordance with 42 U.S.C. 1315a.

"SECTION 16. ORS 243.135, as amended by section 9 of this 2017 Act 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;

"(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 provider-patient relations between a particular panel of 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.

"(8) [*By January 1, 2023, the board shall spend at least 12 percent of its total expenditures in self-insured health benefit plans on payments for primary care*] **If the board spends less than 12 percent of its total expenditures on self-insured health benefit plans on payments for primary care, the board shall implement a plan for increasing the percentage of total expenditures spent on payments for primary care by at least one percent each year**.

"(9) No later than February 1 of each year, the board shall report to the Legislative Assembly on **any plan implemented under subsection (8) of**

this section and on the board's progress toward achieving the target of spending at least 12 percent of total expenditures in self-insured health benefit plans on payments for primary care.

SECTION 17. ORS 243.866, as amended by section 11 of this 2017 Act 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;

"(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 provider-patient relations between a particular panel of 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.

"(9) [*By January 1, 2023, the board shall spend at least 12 percent of its total expenditures in self-insured health benefit plans on payments for primary care*] **If the board spends less than 12 percent of its total expenditures on self-insured health benefit plans on payments for primary care, the board shall implement a plan for increasing the percentage of total expenditures spent on payments for primary care by at least one percent each year**.

"(10) No later than February 1 of each year, the board shall report to the Legislative Assembly on **any plan implemented under subsection (9) of this section and on** the board's progress toward achieving the target of

spending at least 12 percent of total expenditures on payments for primary care.

"SECTION 18. The amendments to ORS 743.010 by section 5 of this 2017 Act apply to rates filed with the Department of Consumer and Business Services for approval on or after the effective date of this 2017 Act.

"SECTION 19. Section 5, chapter 575, Oregon Laws 2015, as amended by section 8, chapter 26, Oregon Laws 2016, is amended to read:

"**Sec. 5.** (1) Sections 1[*, 2 and*] **to** 4, chapter 575, Oregon Laws 2015, are repealed on December 31, [*2018*] **2027**.

"[*(2) Section 3, chapter 575, Oregon Laws 2015, is repealed on January 2, 2020.*]

"**(2) Section 3 of this 2017 Act is repealed on December 31, 2027.**

"SECTION 20. Section 3 of this 2017 Act and the amendments to ORS 414.625, 243.135, 243.866 and 743.010 by sections 14 to 17 of this 2017 Act become operative on January 1, 2023.".
