

Enrolled
House Bill 2267

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CHAPTER

AN ACT

Relating to coordinated care organizations; creating new provisions; and amending ORS 183.310, 414.065, 414.625, 414.627, 414.629 and 414.652.

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

SECTION 1. (1) A coordinated care organization shall collaborate with local public health authorities and hospitals located in areas served by the coordinated care organization to conduct a community health assessment and adopt a community health improvement plan, shared with and endorsed by the coordinated care organization, local public health authorities and hospitals, to serve as a strategic population health and health care services plan for the residents of the areas served by the coordinated care organization, local public health authorities and hospitals. The health improvement plan must include strategies for achieving shared priorities.

(2) The coordinated care organization shall post the health improvement plan to the coordinated care organization's website.

(3) The Oregon Health Authority may prescribe by rule requirements for health improvement plans and provide guidance for aligning the timelines for the development of the community health assessments and health improvement plans by coordinated care organizations, local public health authorities and hospitals.

SECTION 2. (1) As used in this section:

(a) "Attachment point" means the threshold dollar amount, adopted by the Oregon Health Authority by rule, for costs incurred by a coordinated care organization in a calendar year for a member, after which threshold the costs are eligible for state reinsurance payments.

(b) "Coinsurance rate" means the rate, adopted by the authority by rule, at which the authority will reimburse a coordinated care organization for costs incurred by the coordinated care organization in a calendar year after the attachment point and before the reinsurance cap.

(c) "Reinsurance" has the meaning given that term in ORS 731.126.

(d) "Reinsurance cap" means the maximum dollar amount, adopted by the authority by rule, for costs incurred by a coordinated care organization in a calendar year, after which maximum the costs are no longer eligible for state reinsurance payments.

(e) "Reinsurance payment" means a payment by the reinsurance program described in subsection (2) of this section to cover part of a coordinated care organization's costs.

(2) The Oregon Health Authority may establish a reinsurance program to:

(a) Make payments to coordinated care organizations that face particularly high costs in caring for members who require new, exceptionally costly drugs or treatments; and

(b) Better manage costs systemically.

(3) The following requirements apply to a reinsurance program established under subsection (2) of this section:

(a) A coordinated care organization becomes eligible for a reinsurance payment when the coordinated care organization's costs in a calendar year exceed the attachment point. The amount of the payment shall be the product of the coinsurance rate and the coordinated care organization's costs that exceed the attachment point, up to the reinsurance cap.

(b) After the authority adopts by rule the attachment point, reinsurance cap or coinsurance rate for a calendar year, the authority may not:

(A) Change the attachment point or the reinsurance cap during the calendar year; or

(B) Increase the coinsurance rate during the calendar year.

(c) The authority may adopt rules necessary to carry out the provisions of this section including, but not limited to, rules prescribing:

(A) The amount, manner and frequency of reinsurance payments;

(B) Assessments, if any, necessary to provide funding for the program; and

(C) Financial reporting requirements for coordinated care organizations necessary to administer the program.

(d) The authority shall take into account reinsurance payments received by a coordinated care organization in the determination of a global budget for the coordinated care organization.

(4) The authority shall work with the Centers for Medicare and Medicaid Services in establishing a reinsurance program under subsection (2) of this section to ensure compliance with federal requirements and federal financial participation in the costs of the program.

SECTION 3. (1) The Tribal Advisory Council is established. The duties of the council are to:

(a) Serve as a channel of communication between the coordinated care organizations and Indian tribes in this state regarding the health of tribal communities; and

(b) Oversee the tribal liaisons in each coordinated care organization, described in ORS 414.625 (2)(q), and work with coordinated care organizations.

(2) The council consists of members who are appointed by each Indian tribe in this state and one member appointed by the members of the council to represent the urban Indian health programs in this state that are operated by urban Indian organizations pursuant to 25 U.S.C. 1651.

(3) The term of office of each member of the council is four years, but a member serves at the pleasure of the Indian tribe that appointed the member. Before the expiration of the term of a member, the tribe that appointed the member shall appoint a successor whose term begins on January 1 next following. A member is eligible for reappointment. If there is a vacancy for any cause, the vacancy shall be filled by the appointing tribe to become immediately effective for the unexpired term.

(4) Members of the council are not entitled to compensation or reimbursement of expenses and serve as volunteers on the council.

(5) The council shall select one of its members as chairperson and another as vice chairperson, for terms and with duties and powers necessary for the performance of the functions of the offices as the council determines. The chairperson shall be responsible for the adoption of bylaws for the council.

(6) A majority of the members of the council constitutes a quorum for the transaction of business.

(7) The council shall meet at least once every three months at a time and place determined by the council. The council also may meet at other times and places specified by the call of the chairperson or of a majority of the members of the council.

(8) The Oregon Health Authority shall provide staff support to the council.

SECTION 4. ORS 183.310 is amended to read:

183.310. As used in this chapter:

(1) "Agency" means any state board, commission, department, or division thereof, or officer authorized by law to make rules or to issue orders, except those in the legislative and judicial branches.

(2)(a) "Contested case" means a proceeding before an agency:

(A) In which the individual legal rights, duties or privileges of specific parties are required by statute or Constitution to be determined only after an agency hearing at which such specific parties are entitled to appear and be heard;

(B) Where the agency has discretion to suspend or revoke a right or privilege of a person;

(C) For the suspension, revocation or refusal to renew or issue a license where the licensee or applicant for a license demands such hearing; or

(D) Where the agency by rule or order provides for hearings substantially of the character required by ORS 183.415, 183.417, 183.425, 183.450, 183.460 and 183.470.

(b) "Contested case" does not include proceedings in which an agency decision rests solely on the result of a test.

(3) "Economic effect" means the economic impact on affected businesses by and the costs of compliance, if any, with a rule for businesses, including but not limited to the costs of equipment, supplies, labor and administration.

(4) "Hearing officer" includes an administrative law judge.

(5) "License" includes the whole or part of any agency permit, certificate, approval, registration or similar form of permission required by law to pursue any commercial activity, trade, occupation or profession.

(6)(a) "Order" means any agency action expressed orally or in writing directed to a named person or named persons, other than employees, officers or members of an agency. "Order" includes any agency determination or decision issued in connection with a contested case proceeding. "Order" includes:

(A) Agency action under ORS chapter 657 making determination for purposes of unemployment compensation of employees of the state;

(B) Agency action under ORS chapter 240 which grants, denies, modifies, suspends or revokes any right or privilege of an employee of the state; and

(C) Agency action under ORS 468B.050 to issue a permit.

(b) "Final order" means final agency action expressed in writing. "Final order" does not include any tentative or preliminary agency declaration or statement that:

(A) Precedes final agency action; or

(B) Does not preclude further agency consideration of the subject matter of the statement or declaration.

(7) "Party" means:

(a) Each person or agency entitled as of right to a hearing before the agency;

(b) Each person or agency named by the agency to be a party; or

(c) Any person requesting to participate before the agency as a party or in a limited party status which the agency determines either has an interest in the outcome of the agency's proceeding or represents a public interest in such result. The agency's determination is subject to judicial review in the manner provided by ORS 183.482 after the agency has issued its final order in the proceedings.

(8) "Person" means any individual, partnership, corporation, association, governmental subdivision or public or private organization of any character other than an agency.

(9) "Rule" means any agency directive, standard, regulation or statement of general applicability that implements, interprets or prescribes law or policy, or describes the procedure or practice requirements of any agency. The term includes the amendment or repeal of a prior rule, but does not include:

(a) Unless a hearing is required by statute, internal management directives, regulations or statements which do not substantially affect the interests of the public:

(A) Between agencies, or their officers or their employees; or

(B) Within an agency, between its officers or between employees.

(b) Action by agencies directed to other agencies or other units of government which do not substantially affect the interests of the public.

(c) Declaratory rulings issued pursuant to ORS 183.410 or 305.105.

(d) Intra-agency memoranda.

(e) Executive orders of the Governor.

(f) Rules of conduct for persons committed to the physical and legal custody of the Department of Corrections, the violation of which will not result in:

(A) Placement in segregation or isolation status in excess of seven days.

(B) Institutional transfer or other transfer to secure confinement status for disciplinary reasons.

(C) Disciplinary procedures adopted pursuant to ORS 421.180.

(10)(a) "Small business" means a corporation, partnership, sole proprietorship or other legal entity formed for the purpose of making a profit, which is independently owned and operated from all other businesses and which has 50 or fewer employees.

(b) "Small business" does not include a coordinated care organization as defined in ORS 414.025.

SECTION 5. ORS 414.065 is amended to read:

414.065. (1)(a) With respect to health care and services to be provided in medical assistance during any period, the Oregon Health Authority shall determine, subject to such revisions as it may make from time to time and subject to legislative funding and paragraph (b) of this subsection:

(A) The types and extent of health care and services to be provided to each eligible group of recipients of medical assistance.

(B) Standards, including outcome and quality measures, to be observed in the provision of health care and services.

(C) The number of days of health care and services toward the cost of which medical assistance funds will be expended in the care of any person.

(D) Reasonable fees, charges, daily rates and global payments for meeting the costs of providing health services to an applicant or recipient.

(E) Reasonable fees for professional medical and dental services which may be based on usual and customary fees in the locality for similar services.

(F) The amount and application of any copayment or other similar cost-sharing payment that the authority may require a recipient to pay toward the cost of health care or services.

(b) The authority shall adopt rules establishing timelines for payment of health services under paragraph (a) of this subsection.

(2) The types and extent of health care and services and the amounts to be paid in meeting the costs thereof, as determined and fixed by the authority and within the limits of funds available therefor, shall be the total available for medical assistance and payments for such medical assistance shall be the total amounts from medical assistance funds available to providers of health care and services in meeting the costs thereof.

(3) Except for payments under a cost-sharing plan, payments made by the authority for medical assistance shall constitute payment in full for all health care and services for which such payments of medical assistance were made.

(4) Notwithstanding subsections (1) and (2) of this section, the Department of Human Services shall be responsible for determining the payment for Medicaid-funded long term care services and for contracting with the providers of long term care services.

(5) In determining a global budget for a coordinated care organization:

(a) The allocation of the payment, the risk and any cost savings shall be determined by the governing body of the organization;

(b) The authority shall consider the community health assessment conducted by the organization **in accordance with section 1 of this 2019 Act** and reviewed annually, and the organization's health care costs; and

(c) The authority shall take into account the organization's provision of innovative, nontraditional health services.

(6) Under the supervision of the Governor, the authority may work with the Centers for Medicare and Medicaid Services to develop, in addition to global budgets, payment streams:

(a) To support improved delivery of health care to recipients of medical assistance; and

(b) That are funded by coordinated care organizations, counties or other entities other than the state whose contributions qualify for federal matching funds under Title XIX or XXI of the Social Security Act.

SECTION 6. ORS 414.625, as amended by section 3, chapter 49, Oregon Laws 2018, 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 and requirements adopted by the authority under this section must include, but are not limited to, a requirement that the coordinated care organization:

(a) Have demonstrated experience and a capacity for managing financial risk and establishing financial reserves.

(b) Meet the following minimum financial requirements:

(A) Maintain 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) Maintain 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) Expend a portion of the annual net income or reserves of the coordinated care organization that exceed the financial requirements specified in this paragraph on services designed to address health disparities and the social determinants of health consistent with the coordinated care organization's community health improvement plan and transformation plan and the terms and conditions of the Medicaid demonstration project under section 1115 of the Social Security Act (42 U.S.C. 1315).

(c) Operate within a fixed global budget and, by January 1, 2023, spend on primary care, as defined in section 2, chapter 575, Oregon Laws 2015, at least 12 percent of the coordinated care organization's total expenditures for physical and mental health care provided to members, except for expenditures on prescription drugs, vision care and dental care.

(d) Develop and implement alternative payment methodologies that are based on health care quality and improved health outcomes.

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

(f) Engage 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 and requirements 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 and qualified health care interpreters, as those terms are defined in ORS 413.550.

(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, including the services described in ORS 414.766, 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 complies with section 2, chapter 49, Oregon Laws 2018, and that includes:

(A) At least one member representing persons that share in the financial risk of the organization;

(B) A representative of a dental care organization selected by the coordinated care organization;

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

(D) 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;

(E) 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

(F) At least *[one member]* **two members** of the community advisory council, **one of whom is or was within the previous six months a recipient of medical assistance and is at least 16 years of age, or a parent, guardian or primary caregiver of an individual who is or was within the previous six months a recipient of medical assistance.**

(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.

(q) Each coordinated care organization works with the Tribal Advisory Council established in section 3 of this 2019 Act and has a dedicated tribal liaison, selected by the council, to:

(A) Facilitate a resolution of any issues that arise between the coordinated care organization and a provider of Indian health services within the area served by the coordinated care organization;

(B) Participate in the community health assessment and the development of the health improvement plan;

(C) Communicate regularly with the Tribal Advisory Council; and

(D) Be available for training by the office within the authority that is responsible for tribal affairs, any federally recognized tribe in Oregon and the urban Indian health program that is located within the area served by the coordinated care organization and operated by an urban Indian organization pursuant to 25 U.S.C. 1651.

(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 7. ORS 414.625, as amended by section 14, chapter 489, Oregon Laws 2017, and section 4, chapter 49, Oregon Laws 2018, 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 and requirements adopted by the authority under this section must include, but are not limited to, a requirement that the coordinated care organization:

(a) Have demonstrated experience and a capacity for managing financial risk and establishing financial reserves.

(b) Meet the following minimum financial requirements:

(A) Maintain 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) Maintain 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) Expend a portion of the annual net income or reserves of the coordinated care organization that exceed the financial requirements specified in this paragraph on services designed to address health disparities and the social determinants of health consistent with the coordinated care organization's community health improvement plan and transformation plan and the terms and conditions of the Medicaid demonstration project under section 1115 of the Social Security Act (42 U.S.C. 1315).

(c) Operate within a fixed global budget and spend on primary care, as defined by the authority by rule, at least 12 percent of the coordinated care organization's total expenditures for physical and mental health care provided to members, except for expenditures on prescription drugs, vision care and dental care.

(d) Develop and implement alternative payment methodologies that are based on health care quality and improved health outcomes.

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

(f) Engage 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 and requirements 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 and qualified health care interpreters, as those terms are defined in ORS 413.550.

(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, including the services described in ORS 414.766, 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 complies with section 2, chapter 49, Oregon Laws 2018, and that includes:

(A) At least one member representing persons that share in the financial risk of the organization;

(B) A representative of a dental care organization selected by the coordinated care organization;

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

(D) 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;

(E) 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

(F) At least [*one member*] **two members** of the community advisory council, **one of whom is or was within the previous six months a recipient of medical assistance and is at least 16 years of age or a parent, guardian or primary caregiver of an individual who is or was within the previous six months a recipient of medical assistance.**

(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.

(q) Each coordinated care organization works with the Tribal Advisory Council established in section 3 of this 2019 Act and has a dedicated tribal liaison, selected by the council, to:

(A) Facilitate a resolution of any issues that arise between the coordinated care organization and a provider of Indian health services within the area served by the coordinated care organization;

(B) Participate in the community health assessment and the development of the health improvement plan;

(C) Communicate regularly with the Tribal Advisory Council; and

(D) Be available for training by the office within the authority that is responsible for tribal affairs, any federally recognized tribe in Oregon and the urban Indian health program that is located within the area served by the coordinated care organization and operated by an urban Indian organization pursuant to 25 U.S.C. 1651.

(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 8. ORS 414.627 is amended to read:

414.627. (1) A coordinated care organization must have a community advisory council to ensure that the health care needs of the consumers and the community are being addressed. The council must:

(a) Include representatives of the community and of each county government served by the coordinated care organization, but consumer representatives must constitute a majority of the membership; and

(b) Have its membership selected by a committee composed of equal numbers of county representatives from each county served by the coordinated care organization and members of the governing body of the coordinated care organization.

(2) The duties of the council include, but are not limited to:

(a) Identifying and advocating for preventive care practices to be utilized by the coordinated care organization;

(b) Overseeing a community health assessment and adopting a community health improvement plan *[to serve as a strategic population health and health care system service plan for the community served by the coordinated care organization]* **in accordance with section 1 of this 2019 Act**; and

(c) Annually publishing a report on the progress of the community health improvement plan.

(3) The community health improvement plan adopted by the council should describe the scope of the activities, services and responsibilities that the coordinated care organization will consider upon implementation of the plan. The activities, services and responsibilities defined in the plan shall include a plan and a strategy for integrating physical, behavioral and oral health care services and may include, but are not limited to:

(a) Analysis and development of public and private resources, capacities and metrics based on ongoing community health assessment activities and population health priorities;

(b) Health policy;

(c) System design;

(d) Outcome and quality improvement;

(e) Integration of service delivery; and

(f) Workforce development.

(4) The council shall meet at least once every three months. The council shall post a report of its meetings and discussions to the website of the coordinated care organization and other websites appropriate to keeping the community informed of the council's activities. The council, the governing body of the coordinated care organization or a designee of the council or governing body has discretion as to whether public comments received at meetings that are open to the public will be included in the reports posted to the website and, if so, which comments are appropriate for posting.

(5) If the regular council meetings are not open to the public and do not provide an opportunity for members of the public to provide written and oral comments, the council shall hold quarterly meetings:

(a) That are open to the public and attended by the members of the council;

(b) At which the council shall report on the activities of the coordinated care organization and the council;

(c) At which the council shall provide written reports on the activities of the coordinated care organization; and

(d) At which the council shall provide the opportunity for the public to provide written or oral comments.

(6) The coordinated care organization shall post to the organization's website contact information for, at a minimum, the chairperson, a member of the community advisory council or a designated staff member of the organization.

(7) Meetings of the council are not subject to ORS 192.610 to 192.690.

SECTION 9. ORS 414.652, as amended by section 5, chapter 49, Oregon Laws 2018, is amended to read:

414.652. (1) As used in this section:

(a) "Benefit period" means a period of time, shorter than the five-year contract term, for which specific terms and conditions in a contract between a coordinated care organization and the Oregon Health Authority are in effect.

(b) "Renew" means an agreement by a coordinated care organization to amend the terms or conditions of an existing contract for the next benefit period.

(2) A contract entered into between the authority and a coordinated care organization under ORS 414.625 (1):

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

(b) Except as provided in subsection (4) of this section, may not be amended more than once in each 12-month period; and

(c) May be terminated by the authority if a coordinated care organization fails to meet outcome and quality measures specified in the contract or is otherwise in breach of the contract.

(3) 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.

(4) A contract entered into between the authority and a coordinated care organization may be amended:

(a) More than once in each 12-month period if:

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

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

(b) Once within the first eight months of the effective date of the contract if needed to adjust the global budget of a coordinated care organization, retroactive to the beginning of the calendar year, to take into account changes in the membership of the coordinated care organization or the health status of the coordinated care organization's members.

(5) Except as provided in subsection (7) of this section, the authority must 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.

(6) **Except as provided in subsection (4)(b) of this section**, 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.

(7) No later than 134 days prior to the end of a benefit period, the authority shall provide to each coordinated care organization notice of the proposed changes to the terms and conditions of a contract, as will be submitted to the Centers for Medicare and Medicaid Services for approval, for the next benefit period.

(8) A coordinated care organization must notify the authority of the coordinated care organization's refusal to renew a contract with the authority no later than 14 days after the authority provides the notice described in subsection (7) of this section. Except as provided in subsections (9) and (10) of this section, a refusal to renew terminates the contract at the end of the benefit period.

(9) The authority may require a contract to remain in force into the next benefit period and be amended as proposed by the authority until 90 days after the coordinated care organization has, in accordance with criteria prescribed by the authority:

(a) Notified each of its members and contracted providers of the termination of the contract;

(b) Provided to the authority a plan to transition its members to another coordinated care organization; and

(c) Provided to the authority a plan for closing out its coordinated care organization business.

(10) The authority may waive compliance with the deadlines in subsections (8) and (9) of this section if the Director of the Oregon Health Authority finds that the waiver of the deadlines is consistent with the effective and efficient administration of the medical assistance program and the protection of medical assistance recipients.

SECTION 10. ORS 414.629 is amended to read:

414.629. (1) A community health improvement plan adopted by a coordinated care organization and its community advisory council in accordance with [ORS 414.627] **section 1 of this 2019 Act** shall include **a component for addressing the health of children and youth in the areas served by the coordinated care organization including**, to the extent practicable, a strategy and a plan for:

(a) Working with programs developed by the Early Learning Council, Early Learning Hubs, the Youth Development Council and the school health providers in the region; and

(b) Coordinating the effective and efficient delivery of health care to children and adolescents in the community.

(2) A community health improvement plan must be based on research, including research into adverse childhood experiences, and must identify funding sources and additional funding necessary to address the health needs of children and adolescents in the community and to meet the goals of the plan. The plan must also:

(a) Evaluate the adequacy of the existing school-based health resources including school-based health centers and school nurses to meet the specific pediatric and adolescent health care needs in the community;

(b) Make recommendations to improve the school-based health center and school nurse system, including the addition or improvement of electronic medical records and billing systems;

(c) Take into consideration whether integration of school-based health centers with the larger health system or system of community clinics would further advance the goals of the plan;

(d) Improve the integration of all services provided to meet the needs of children, adolescents and families;

(e) Focus on primary care, behavioral health and oral health; and

(f) Address promotion of health and prevention and early intervention in the treatment of children and adolescents.

(3) A coordinated care organization shall involve in the development of its community health improvement plan, school-based health centers, school nurses, school mental health providers and individuals representing:

(a) Programs developed by the Early Learning Council and Early Learning Hubs;

(b) Programs developed by the Youth Development Council in the region;

(c) The Healthy Start Family Support Services program in the region;

(d) The Health Care for All Oregon Children program and other medical assistance programs;

(e) Relief nurseries in the region;

(f) Community health centers;

(g) Oral health care providers;

(h) Community mental health providers;

(i) Administrators of county health department programs that offer preventive health services to children;

(j) Hospitals in the region; and

(k) Other appropriate child and adolescent health program administrators.

(4) The Oregon Health Authority may provide incentive grants to coordinated care organizations for the purpose of contracting with individuals or organizations to help coordinate integration strategies identified in the community health improvement plan adopted by the community advisory council. The authority may also provide funds to coordinated care organizations to improve systems of services that will promote the implementation of the plan.

(5) Each coordinated care organization shall report to the authority, in the form and manner prescribed by the authority, on the progress of the integration strategies and implementation of the plan for working with the programs developed by the Early Learning Council, Early Learning Hubs, the Youth Development Council and school health care providers in the region, as part of the development and implementation of the community health improvement plan. The authority shall compile the information biennially and report the information to the Legislative Assembly by December 31 of each even-numbered year.

Passed by House June 12, 2019

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Timothy G. Sekerak, Chief Clerk of House

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Tina Kotek, Speaker of House

Passed by Senate June 19, 2019

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Peter Courtney, President of Senate

Received by Governor:

.....M,....., 2019

Approved:

.....M,....., 2019

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Kate Brown, Governor

Filed in Office of Secretary of State:

.....M,....., 2019

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Bev Clarno, Secretary of State