Senate Bill 1041

Sponsored by COMMITTEE ON HEALTH CARE

SUMMARY

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

Grants to Oregon Health Authority powers to regulate financial condition of coordinated care organizations that align with powers of Department of Consumer and Business Services to regulate domestic insurers.

A BILL FOR AN ACT

Relating to the regulation of coordinated care organizations; creating new provisions; and amending ORS 413.032, 413.037, 413.181 and 414.625.

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

SECTION 1. As used in sections 1 to 52 of this 2019 Act:

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

(2) "Medical assistance program" means the Oregon Integrated and Coordinated Health Care Delivery System established in ORS 414.620.

SECTION 2. (1) An officer or employee of the Oregon Health Authority who is delegated responsibilities in the enforcement of sections 1 to 52 of this 2019 Act or rules adopted pursuant to section 53 of this 2019 Act may not:

(a) Be a director, officer or employee of or be financially interested in any coordinated care organization, except as a member of a coordinated care organization or by reason of rights vested in compensation or benefits related to services performed prior to affiliation with the authority; or

(b) Be engaged in any other business or occupation interfering with or inconsistent with the duties of the authority.

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

SECTION 3. (1) The Oregon Health Authority shall enforce the provisions of sections 1 to 52 of this 2019 Act and rules adopted pursuant to section 53 of this 2019 Act for the public good.

(2) The authority has the powers and authority expressly conferred by or reasonably implied from the provisions of sections 1 to 52 of this 2019 Act and rules adopted pursuant to section 53 of this 2019 Act.

(3) The authority may conduct examinations and investigations of matters concerning the regulation of coordinated care organizations as the authority considers proper to determine whether any person has violated any provision of sections 1 to 52 of this 2019 Act or rules adopted pursuant to section 53 of this 2019 Act or to secure information useful in the lawful administration of any of the provisions.

SECTION 4. (1) The Oregon Health Authority shall hold a contested case hearing upon

NOTE: Matter in **boldfaced** type in an amended section is new; matter [*italic and bracketed*] is existing law to be omitted. New sections are in **boldfaced** type.

written request for a hearing by a person aggrieved by any act, threatened act or failure of the authority to act under sections 1 to 52 of this 2019 Act or rules adopted pursuant to section 53 of this 2019 Act.

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

SECTION 5. A person may not file or cause to be filed with the Oregon Health Authority any article, certificate, report, statement, application or other information required or permitted to be filed under sections 1 to 52 of this 2019 Act or rules adopted pursuant to section 53 of this 2019 Act that is known by the person to be false or misleading in any material respect.

SECTION 6. The Oregon Health Authority may request information from any coordinated care organization or its officers in relation to the activities or condition of the coordinated care organization or any other matter connected with a coordinated care organization's transactions, and the person of whom the information is requested shall promptly and truthfully reply using the form of communication requested by the authority and verified by an officer of the coordinated care organization, if the authority so requires. A response is subject to the provisions of section 5 of this 2019 Act.

SECTION 7. The Oregon Health Authority shall examine every coordinated care organization, including an audit of the financial affairs of the coordinated care organization, as often as the authority determines an examination to be necessary but at least once every five years. An examination shall be conducted for the purpose of determining the financial condition of the coordinated care organization, its ability to fulfill its obligations and its manner of fulfillment, the nature of its operations and its compliance with sections 1 to 52 of this 2019 Act or rules adopted pursuant to section 53 of this 2019 Act. The authority may also examine any person holding the capital stock of a coordinated care organization for the purpose of controlling the management of the coordinated care organization as a voting trustee or otherwise.

SECTION 8. The Oregon Health Authority, whenever the authority deems it advisable in the interest of members of a coordinated care organization or for the public good, shall investigate into the affairs of:

(1) A coordinated care organization;

(2) A person proposing to form a coordinated care organization; or

(3) A person holding the capital stock of one or more coordinated care organizations for the purpose of controlling the management of the coordinated care organization as a voting trustee or otherwise.

SECTION 9. (1) When the Oregon Health Authority determines that an examination should be conducted, the authority shall appoint one or more examiners to perform the examination and instruct them as to the scope of the examination. The authority may prescribe the examiner handbook and employ other guidelines and procedures that the authority determines to be appropriate.

(2) The authority may retain appraisers, independent actuaries, independent certified public accountants or other professionals and specialists in conducting an examination, as needed. The coordinated care organization that is the subject of the examination is responsible for the cost of retaining the professionals and specialists.

(3) Upon an examination or investigation of a coordinated care organization, the Oregon

Health Authority may examine under oath all persons who may have material information regarding the property or business of the coordinated care organization being examined or investigated.

(4) Every person being examined or investigated shall produce all books, records, accounts, papers, documents and computer and other recordings in its possession or control relating to the matter under examination or investigation, including, in the case of an examination, the property, assets, business and affairs of the person.

(5) With regard to an examination, the officers, directors and agents of the coordinated care organization being examined shall provide timely, convenient and free access at all reasonable hours at the offices of the coordinated care organization being examined to all books, records, accounts, papers, documents and computer and other recordings. The officers, directors, employees and agents of the person must facilitate the examination.

(6) In an investigation or examination of a coordinated care organization's financial condition, the authority may order a coordinated care organization to produce information the coordinated care organization does not possess but to which the coordinated care organization might have access by reason of a contractual relationship or a statutory obligation or by other means. If the coordinated care organization cannot obtain the information the authority requires, the coordinated care organization shall provide the authority with a detailed explanation of the reason the coordinated care organization cannot obtain the information and shall identify the person that possesses the information. If the authority finds that the coordinated care organization's explanation is without merit, the authority may impose a civil penalty on the coordinated care organization as provided in rules adopted pursuant to section 53 (2)(g) of this 2019 Act or may suspend or revoke the coordinated care organization's contract.

SECTION 10. (1) Not later than the 60th day after an examination is completed, the examiner in charge of the examination shall submit to the Oregon Health Authority a full and true report of the examination, verified by the oath of the examiner. The report shall comprise only facts appearing upon the books, papers, records, accounts, documents or computers and other recordings of the coordinated care organization, its agents or other persons being examined or facts ascertained from testimony of individuals concerning the affairs of the coordinated care organization, together with such conclusions and recommendations as reasonably may be warranted from the facts.

(2) The authority shall make a copy of the report submitted under subsection (1) of this section available to the coordinated care organization that is the subject of the examination and shall give the coordinated care organization an opportunity to review and comment on the report. The authority may request additional information or meet with the coordinated care organization for the purpose of resolving questions or obtaining additional information and may direct the examiner to consider the additional information for inclusion in the report.

(3) Before the authority files the examination report as a final examination report or makes the report or any matters relating to it public, the coordinated care organization being examined shall have an opportunity for a hearing. A copy of the report must be mailed by certified mail to the coordinated care organization being examined. The coordinated care organization may request a hearing not later than the 30th day after the date on which the report was mailed. This subsection does not prohibit the authority from disclosing a final

examination report as provided in subsection (5) of this section.

(4) The authority shall consider comments presented at a hearing requested under subsection (3) of this section and may direct the examiner to consider the comments or direct that the comments be included in documentation relating to the report, although not as part of the report itself. The authority may file the report as a final examination report at any time after consideration of the comments or at any time after the period for requesting a hearing has passed if a hearing is not requested.

(5) A report filed as a final examination report is subject to public inspection. The authority, after filing any report, if the authority considers it to be in the public interest, may publish any report or the result of any examination contained in the report without expense to the person examined.

SECTION 11. A person examined under section 9 of this 2019 Act shall pay the costs of the examination to the Oregon Health Authority as determined by the authority, including actual and necessary transportation and traveling expenses.

SECTION 12. (1) A complaint made to the Oregon Health Authority against a coordinated care organization for a violation of sections 1 to 52 of this 2019 Act or rules adopted pursuant to section 53 of this 2019 Act, and the record of the complaint, is confidential and may not be disclosed except as provided in ORS 413.175 or 414.679. The complaint, and the record of the complaint, may not be used in any action, suit or proceeding except to the extent the authority considers necessary in prosecuting apparent violations of sections 1 to 52 of this 2019 Act, rules adopted pursuant to section 53 of this 2019 Act or other law.

(2) Data gathered pursuant to an investigation by the authority of a complaint is confidential, may not be disclosed except as provided in ORS 413.175 and 414.679 and may not be used in any action, suit or proceeding except to the extent the authority considers necessary in investigating or prosecuting apparent violations of sections 1 to 52 of this 2019 Act, rules adopted pursuant to section 53 of this 2019 Act or other law.

(3) Notwithstanding subsections (1) and (2) of this section, the authority shall establish by rule a method for publishing an annual statistical report containing the coordinated care organization's name and the number, percentage, type and disposition of complaints the authority receives against each coordinated care organization that contracts with the authority.

SECTION 13. (1) Except in the case of malfeasance in office or willful or wanton neglect of duty, a cause of action does not arise and liability may not be imposed against the Oregon Health Authority, an authorized representative of the authority or any examiner appointed by the authority for:

(a) Any statements made or conduct performed in good faith pursuant to an examination or investigation.

(b) The authority's collection, review, analysis or dissemination of the data and information collected from the filings required by rules adopted by sections 1 to 52 of this 2019 Act or rules adopted pursuant to section 53 of this 2019 Act.

(2) A cause of action does not arise and liability may not be imposed against any person for communicating or delivering information or data to the authority or an authorized representative of the authority or examiner pursuant to an examination or investigation if the communication or delivery was performed in good faith and without fraudulent intent or an intent to deceive.

(3) This section does not abrogate or modify in any way any common law or statutory privilege or immunity otherwise enjoyed by any person to which subsection (1) or (2) of this section applies.

(4) The court may award reasonable attorney fees to the prevailing party in a cause of action arising out of activities of the authority or an examiner in carrying out an examination or investigation.

SECTION 14. (1) The Oregon Health Authority may disclose or use a report as considered necessary by the authority in the administration of sections 1 to 52 of this 2019 Act, rules adopted pursuant to section 53 of this 2019 Act or other law.

(2) A report filed with the authority according to requirements established by rule for disclosure of material acquisitions or dispositions of assets is confidential.

(3) A report filed with the Oregon Health Authority according to requirements established by rule for the purpose of determining the amount of restricted reserves, capital or surplus that a coordinated care organization must maintain under ORS 414.625 (1)(b)(A) is confidential and may not be disclosed.

(4) A financial plan of action stating corrective actions to be taken by a coordinated care organization in response to a determination of inadequate restricted reserves, capital or surplus that is filed by the coordinated care organization with the authority according to requirements established by rule is confidential and may not be disclosed.

(5) The results or report of any examination or analysis of a coordinated care organization performed by the authority in connection with a financial plan described in subsection (4) of this section and any corrective order issued by the authority pursuant to such an examination or analysis is confidential and may not be disclosed.

(6) Information contained in documents described in subsections (1) to (4) of this section that is also contained in final examination reports filed under section 10 of this 2019 Act is not confidential under this section.

(7) All financial analysis ratios and examination synopses concerning coordinated care organizations that are submitted to the authority are confidential.

SECTION 15. (1) The Oregon Health Authority may use reports and financial plans of action that are made confidential under section 14 of this 2019 Act only for the purpose of monitoring the solvency of coordinated care organizations and the need for possible corrective action with respect to coordinated care organizations.

(2) The authority may not use reports and financial plans of action referred to in subsection (1) of this section for establishing global budgets or in any proceeding related to global budgets.

(3) This section does not prohibit authority from using information included in reports or financial plans referred to in subsection (1) of this section that is available from other sources.

SECTION 16. As used in sections 16 to 22 of this 2019 Act:

(1) "Compliance audit" means a voluntary internal evaluation, review, assessment, audit or investigation that is undertaken to identify or prevent noncompliance with, or promote compliance with, laws, regulations, orders or professional standards, and that is conducted by or on behalf of a coordinated care organization.

(2)(a) "Compliance self-evaluative audit document" means a document prepared as a result of or in connection with a compliance audit.

(b) "Compliance self-evaluative audit document" includes, but is not limited to:

(A) A written response to the findings of a compliance audit.

(B) Field notes and records of observations, findings, opinions, suggestions, conclusions, drafts, memoranda, drawings, photographs, exhibits, computer-generated or electronically recorded information, phone records, maps, charts, graphs and surveys, provided this supporting information is collected or developed solely for the purpose of a compliance audit.

(C) A compliance audit report prepared by an auditor, who may be an employee of the coordinated care organization or an independent contractor, which may include the scope of the audit, the information gained in the audit and conclusions and recommendations, with exhibits and appendices.

(D) Memoranda and documents analyzing portions or all of the compliance audit report and discussing potential implementation issues.

(E) An implementation plan that addresses correcting past noncompliance, improving current compliance and preventing future noncompliance.

(F) Analytic data generated in the course of conducting the compliance audit, not including any analytic data that exists independently of the audit or existed before the audit was conducted.

SECTION 17. Except as provided in sections 16 to 22 of this 2019 Act:

(1) A compliance self-evaluative audit document is privileged information and is not discoverable or admissible as evidence in any civil, criminal or administrative proceeding.

(2) Any person who performs or directs the performance of an compliance audit, any officer, employee or agent of a coordinated care organization who is involved with a compliance audit and any consultant who is hired for the purpose of performing a compliance audit may not be examined in any civil, criminal or administrative proceeding about the compliance audit or any compliance self-evaluative audit document.

SECTION 18. (1) Section 17 of this 2019 Act does not prohibit the Oregon Health Authority from acquiring any compliance self-evaluative audit document or examining any person in connection with the document. If the authority determines that the actions of a coordinated care organization are egregious, the authority may introduce and use the document in any administrative proceeding or civil action under sections 1 to 52 of this 2019 Act or rules adopted pursuant to section 53 of this 2019 Act.

(2) Any compliance self-evaluative audit document submitted to the authority under this section and in the possession of the authority remains the property of the coordinated care organization and is not subject to disclosure or production under ORS 192.311 to 192.478.

(3)(a) The authority shall consider the corrective action taken by a coordinated care organization to eliminate problems identified in the compliance self-evaluative audit document as a mitigating factor when determining a civil penalty or other action against the coordinated care organization.

(b) The authority may, in the authority's sole discretion, decline to impose a civil penalty or take other action against a coordinated care organization based on information obtained from a compliance self-evaluative audit document if the coordinated care organization has taken reasonable corrective action to eliminate the problems identified in the document.

(4) Disclosure of a compliance self-evaluative audit document to a governmental agency, whether voluntarily or pursuant to compulsion of law, does not constitute a waiver of the privilege set forth in section 17 of this 2019 Act for any other purpose.

(5) The authority may not be compelled to produce a compliance self-evaluative audit document.

SECTION 19. (1) The privilege set forth in section 17 of this 2019 Act does not apply to the extent that the privilege is expressly waived by the coordinated care organization that prepared or caused to be prepared the compliance self-evaluative audit document.

(2) The privilege set forth in section 17 of this 2019 Act does not apply in any civil, criminal or administrative proceeding commenced by the Attorney General relating to Medicaid fraud, without regard to whether the proceeding is brought on behalf of the state, a state agency or a federal agency. A coordinated care organization may request an in camera review of any document or other evidence to be released or used under this subsection and may request that appropriate protective orders be entered governing release and use of the material.

(3) In any civil proceeding a court of record may, after an in camera review, require disclosure of material for which the privilege set forth in section 17 of this 2019 Act is asserted if the court determines that the material is not subject to the privilege, or that the privilege is asserted for a fraudulent purpose, including but not limited to an assertion of the privilege for a compliance audit that was conducted for the purpose of concealing a violation of any federal, state or local law or rule. This subsection may not be construed to prohibit the Oregon Health Authority from acquiring, examining and using compliance self-evaluative audit documents under section 17 of this 2019 Act.

(4) In a criminal proceeding, a court of record may, after an in camera review, require disclosure of material for which the privilege set forth in section 17 of this 2019 Act is asserted if the court determines that:

(a) The privilege is asserted for a fraudulent purpose, including but not limited to an assertion of the privilege for a compliance audit that was conducted for the purpose of concealing a violation of any federal, state or local law or rule;

(b) The material is not subject to the privilege; or

(c) The material contains evidence relevant to commission of a criminal offense, and:

(A) A district attorney or the Attorney General has a compelling need for the information;

(B) The information is not otherwise available; or

(C) The district attorney or Attorney General is unable to obtain the substantial equivalent of the information by any other means without incurring unreasonable cost and delay.

SECTION 20. (1) Within 30 days after a district attorney or the Attorney General serves on a coordinated care organization a written request by certified mail for disclosure of a compliance self-evaluative audit document, the coordinated care organization that prepared or caused the document to be prepared may file in circuit court a petition requesting an in camera hearing on whether the compliance self-evaluative audit document or portions of the document are privileged under section 17 of this 2019 Act or subject to disclosure. Failure by the coordinated care organization to file a petition waives the privilege only with respect to the specific request.

(2) A petition filed by a coordinated care organization under this section must contain the following information:

(a) The date of the compliance self-evaluative audit document.

(b) The identity of the person that conducted the audit.

(c) The general nature of the activities covered by the compliance audit.

(d) An identification of the portions of the compliance self-evaluative audit document for which the privilege is being asserted.

(3) Within 45 days after the filing of a petition by a coordinated care organization under this section, the court shall schedule an in camera hearing to determine whether the compliance self-evaluative audit document or portions of the document are privileged under section 17 of this 2019 Act.

(4) The court, after an in camera review pursuant to this section, may require disclosure of material for which the privilege established by section 17 of this 2019 Act is asserted if the court determines that any of the conditions set forth in section 19 or 21 of this 2019 Act are met. Upon making such a determination, the court may compel the disclosure of only those portions of a compliance self-evaluative audit document relevant to issues in dispute in the underlying proceeding. Any disclosure that is compelled by the court will not be considered to be a public document or be deemed to be a waiver of the privilege for any other civil, criminal or administrative proceeding. A party unsuccessfully opposing disclosure may apply to the court for an appropriate order protecting the document from further disclosure.

(5) A coordinated care organization asserting the privilege established under section 17 of this 2019 Act has the burden of establishing that the privilege applies. If the coordinated care organization establishes that the privilege applies, a party seeking disclosure under section 19 of this 2019 Act has the burden of proving the elements set forth in section 19 of this 2019 Act.

SECTION 21. The privilege established under section 17 of this 2019 Act does not apply to any of the following:

(1) Documents, communications, data, reports or other information expressly required to be collected, developed, maintained or reported to the Oregon Health Authority or other regulatory agency under sections 1 to 52 of this 2019 Act, rules adopted pursuant to section 53 of this 2019 Act or other state or federal law;

(2) Information obtained by observation or monitoring by the authority or any regulatory agency; or

(3) Information obtained from a source other than the compliance audit.

SECTION 22. Nothing in sections 16 to 22 of this 2019 Act, or in the release of any compliance self-evaluative audit document under sections 16 to 22 of this 2019 Act, shall limit, waive or abrogate the scope or nature of any statutory or common law privilege or other limitation on admissibility of evidence including, but not limited to, the work product doctrine, the lawyer-client privilege under ORS 40.225 or the subsequent remedial measures exclusion provided by ORS 40.185.

SECTION 23. (1) An officer, manager, member of the governing board, trustee, owner, employee or agent of a coordinated care organization, and any other person with authority over or in charge of any portion of the coordinated care organization's affairs, including any person who exercises control directly or indirectly over the activities of the coordinated care organization through a holding company or other affiliate of the coordinated care organization, shall cooperate with the Oregon Health Authority in any delinquency proceeding or any investigation preliminary to the proceeding. For purposes of this section, cooperation with the authority includes at least the following:

(a) Replying promptly in writing to any inquiry from the authority requesting such a

reply; and

(b) Making available to the authority any books, accounts, documents or other records, information or property of or pertaining to the coordinated care organization and in the possession, custody or control of the coordinated care organization.

(2) A person may not obstruct or interfere with the authority in conducting a delinquency proceeding or any investigation that is preliminary or incidental to a delinquency proceeding.

(3) This section may not be construed to abridge existing legal rights, including the right to resist a petition for liquidation or other delinquency proceedings, or other orders.

SECTION 24. (1) For any reason stated in subsection (2) of this section, the Oregon Health Authority may order a coordinated care organization to be placed under supervision.

(2) The authority may place a coordinated care organization under supervision if upon examination or at any other time the authority determines that:

(a) The condition of the coordinated care organization renders the continuance of its business hazardous to the public or to its members.

(b) The coordinated care organization has refused to permit examination of its books, papers, accounts, records or affairs by the authority or any deputy, examiner or employee representing the authority.

(c) A coordinated care organization has unlawfully removed from this state books, papers, accounts or records necessary for an examination of the coordinated care organization.

(d) The coordinated care organization has failed to comply promptly with the applicable financial reporting statutes or rules and any request of the authority relating to financial reporting.

(e) The coordinated care organization has failed to observe an order of the authority to make good, within the time prescribed by law, any prohibited deficiency in its restricted reserves, capital, capital stock or surplus.

(f) The coordinated care organization is continuing to conduct business after its contract has been revoked or suspended by the authority.

(g) The coordinated care organization, by contract or otherwise, has done any of the following unlawfully, in violation of an order of the authority or without first having obtained written approval of the authority:

(A) Totally reinsured its entire outstanding business; or

(B) Merged or consolidated substantially its entire property or business with another entity.

(h) The coordinated care organization has engaged in any transaction in which it is not authorized to engage under the laws of the state.

(i) The coordinated care organization has failed to comply with any other order of the authority.

(j) The coordinated care organization has failed to comply with any other applicable provisions of sections 1 to 52 of this 2019 Act or rules adopted pursuant to section 53 of this 2019 Act.

(k) The business of the coordinated care organization is being conducted fraudulently.

(L) The coordinated care organization agrees to supervision.

(3) If the authority determines that one or more conditions set forth in subsection (2) of this section exist, the authority may do all of the following:

(a) Notify the coordinated care organization of the determination of the authority.

(b) Furnish to the coordinated care organization a written list of the requirements to abate the condition or conditions determined to exist.

(c) Notify the coordinated care organization that it is under the supervision of the authority and that the authority is applying this section and section 25 of this 2019 Act.

(4) The authority may act as the supervisor to conduct the supervision and otherwise carry out an order under subsection (1) of this section or may appoint another person as supervisor.

(5) The authority or the appointed supervisor may prohibit any person from taking any of the following actions during the period of supervision without the prior approval of the authority or supervisor:

(a) Disposing of, conveying or encumbering any of the coordinated care organization's assets or its business in force.

(b) Withdrawing from any of the coordinated care organization's bank accounts.

(c) Lending any of the coordinated care organization's funds.

(d) Investing any of the coordinated care organization's funds.

(e) Transferring any of the coordinated care organization's property.

(f) Incurring any debt, obligation or liability on behalf of the coordinated care organization.

(g) Merging or consolidating the coordinated care organization with another coordinated care organization or other person.

(h) Entering into any new reinsurance contract or treaty.

(i) Making any material change in management.

(j) Increasing salaries and benefits of officers or directors.

(k) Making or increasing preferential payment of bonuses, dividends or other payments determined by the authority to be preferential.

(L) Any other action affecting the business or condition of the coordinated care organization.

(6) The authority may apply to any circuit court for any restraining order, preliminary and permanent injunctions and other orders necessary to enforce a supervision order.

(7) During the period of supervision, the coordinated care organization may file a written request for a hearing to review the supervision or any action taken or proposed to be taken. A request under this subsection does not suspend the supervision. The coordinated care organization must specify in the request the manner in which the action being complained of would not result in improving the condition of the coordinated care organization. The hearing shall be held within 30 days after the filing of the request. The authority shall complete the review of the supervision or other action and shall take action under subsection (8) of this section if appropriate within 30 days after the record for the hearing is closed.

(8) The authority shall release a coordinated care organization from supervision if the authority determines upon hearing that none of the conditions giving rise to the supervision exist.

SECTION 25. (1) A coordinated care organization placed under supervision must correct, eliminate or remedy the acts, transactions or practices that are the basis for the order of supervision and otherwise comply with the requirements of the Oregon Health Authority within the period of time allowed by the authority, not to exceed 60 days, after the date on

which the order is served on the coordinated care organization.

(2) If the authority determines that the conditions giving rise to the supervision still exist at the end of the supervision period established in subsection (1) of this section, the authority may extend the period.

(3) During the period of supervision of a coordinated care organization, the authority may institute rehabilitation or liquidation proceedings, extend the period of supervision or take any other action authorized by law.

(4) The authority or supervisor on behalf of a coordinated care organization under supervision may bring an action for damages against any person who violates any order of the authority under section 24 of this 2019 Act if the violation reduces the net worth of the coordinated care organization or results in loss to the coordinated care organization that the coordinated care organization would not have suffered otherwise. The authority or supervisor may recover damages to the extent of the reduction or loss.

SECTION 26. (1) Whenever the Oregon Health Authority determines from any showing or statement made to the authority from any examination made by the authority that the assets of a coordinated care organization are less than its liabilities plus required capitalization, the authority may:

(a) Proceed immediately to petition for an order of rehabilitation or liquidation or to commence a delinquency proceeding; or

(b) Allow the coordinated care organization a period of time, not to exceed 90 days, in which to make good the amount of the impairment with cash or authorized investments.

(2) If the amount of the impairment is not made good within the time prescribed by the authority under subsection (1) of this section, the authority shall proceed to petition for an order of rehabilitation or liquidation or to commence a delinquency proceeding.

(3) An order directing a coordinated care organization to cure an impairment is confidential for such time as the authority considers proper but not exceeding the time prescribed by the authority for making the amount of the impairment good. If the authority determines that the public interest in disclosure outweighs the public interest in protecting or salvaging the solvency of the coordinated care organization, the authority may make the order available for public inspection.

SECTION 27. (1) The Oregon Health Authority may petition the circuit court for an order:

(a) Directing the authority to rehabilitate a coordinated care organization on one or more of the following grounds:

(A) The coordinated care organization is impaired.

(B) The coordinated care organization has failed to submit its books, papers, accounts or affairs for the reasonable inspection and examination by the authority.

(C) Without first obtaining the written consent of the authority, the coordinated care organization has by contract of reinsurance, or otherwise, transferred or attempted to transfer substantially its entire property or business, or has entered into any transaction the effect of which is to merge, consolidate or reinsure substantially its entire property or business in or with the property or business of any other person, without first having complied with rules adopted pursuant to section 53 (2)(i) of this 2019 Act.

(D) The coordinated care organization is in such condition that its further transaction of business would be hazardous to its members, creditors, the state or the public.

(E) The coordinated care organization has violated its articles of incorporation, its bylaws, any law of the state or any order of the authority.

(F) Any person who has executive authority in the coordinated care organization, whether an officer, manager, general agent, member of the governing board or trustee, employee or other person, has refused to be examined under oath by the authority concerning its affairs, whether in this state or elsewhere, and after reasonable notice of the fact, the coordinated care organization has not promptly and effectively terminated the employment and status of the person and all influence of the person on management.

(G) The coordinated care organization or its property has been or is the subject of an application for the appointment of a receiver, trustee, custodian, conservator or sequestrator or similar fiduciary of the coordinated care organization or of its property other than as authorized under sections 1 to 52 of this 2019 Act and rules adopted pursuant to section 53 of this 2019 Act, and the appointment has been made or is imminent, and the appointment might deprive the courts of this state of jurisdiction or might prejudice orderly delinquency proceedings.

(H) The coordinated care organization has consented to the order by a vote of a majority of its governing board.

(I) The coordinated care organization has failed to pay any obligation to any state or any subdivision of the state.

(J) The coordinated care organization has failed to pay a binding final judgment rendered against it by the later of:

(i) Sixty days after the judgment became final;

(ii) Sixty days after the time for taking an appeal expired; or

(iii) Sixty days after the dismissal of an appeal before final determination.

(K) There is reasonable cause to believe that there has been embezzlement from the coordinated care organization, wrongful sequestration or diversion of the coordinated care organization's assets, forgery or fraud affecting the coordinated care organization or other illegal conduct in, by or with respect to the coordinated care organization that if established would endanger assets in an amount threatening the solvency of the coordinated care organization.

(L) The coordinated care organization has failed to remove a person who has executive authority in the coordinated care organization, whether an officer, manager, general agent, member of the governing board, trustee, employee or other person, if the person has been found by the authority to be dishonest or untrustworthy in a way affecting the coordinated care organization's business.

(M) Control of the coordinated care organization, whether by stock ownership or otherwise, and whether direct or indirect, is in a person or persons who have been found by the authority to be untrustworthy.

(N) The coordinated care organization has failed to file reports or financial data required by statute or by rule within the time allowed by law or within any additional time allowed by the authority.

(b) Authorizing the authority to seize all or part of the property, books, accounts and other records of a coordinated care organization as well as the premises where health services are provided or administrative functions for a coordinated care organization are housed.

(c) Enjoining the coordinated care organization from disposing of its property and transacting business except as allowed by written consent of the authority.

(2) The authority must include all of the following in the petition under subsection (1) of this section:

(a) An allegation that one or more grounds exist that would justify a court order for a rehabilitation or liquidation proceeding against the coordinated care organization.

(b) An allegation that the interests of members of the coordinated care organization, creditors of the coordinated care organization or the public will be endangered by delay.

(c) The contents of the order that the authority requests the court to issue.

SECTION 28. (1) Upon petition by the Oregon Health Authority under section 27 of this 2019 Act, the court may issue the requested order immediately, ex parte and without hearing. The court in its order shall specify the duration of the order. The duration of an order shall be a period sufficient to enable the authority to ascertain the condition of the coordinated care organization.

(2) On motion of the authority or the coordinated care organization against whom an order under this section is issued, or on the court's own motion, the court may hold such hearings from time to time as the court determines are desirable, after such notice as it determines appropriate, and may extend, shorten or modify the terms of the order.

(3) The court may vacate an order issued under this section if the court determines that the authority has not commenced a rehabilitation or liquidation proceeding within a reasonable time.

(4) An order of the court directing a rehabilitation or liquidation proceeding vacates the order issued under this section.

(5) Entry of a seizure order under this section does not constitute an anticipatory breach of any contract of the coordinated care organization.

(6) At any time after a court issues an order under this section, the court may direct that notice of the order be given to a person if the court determines both of the following:

(a) That the person was not notified of the hearing on the order and did not appear at the hearing.

(b) That the interest of the person is or will be substantially affected by the order.

SECTION 29. (1) An order to rehabilitate a coordinated care organization shall direct the Oregon Health Authority to take possession of the property of the coordinated care organization and to conduct the business of the coordinated care organization, and to take such steps toward removing the causes and conditions that made rehabilitation necessary as directed by the court.

(2) If at any time the authority deems that further efforts to rehabilitate the coordinated care organization would be useless, the authority may apply to the court for an order of liquidation under section 51 of this 2019 Act.

(3) The authority may apply at any time for an order terminating the rehabilitation proceeding and permitting the coordinated care organization to resume possession of its property and the conduct of its business, but the order may not be granted except after a full hearing.

SECTION 30. The Oregon Health Authority, after taking possession of the property and business of any coordinated care organization, shall:

(1) Subject to a court's direction, immediately conduct the business of the coordinated

care organization or take steps authorized by law to rehabilitate, liquidate or conserve the coordinated care organization;

(2) Be vested with the coordinated care organization's title and interest in and to all assets and property of every kind, both tangible and intangible;

(3) Possess, in the name of the coordinated care organization or in the name of the authority, all rights, privileges, powers and authority granted to coordinated care organizations in this state or otherwise possessed by coordinated care organizations generally, without regard to any limitations prescribed in the articles or bylaws of the coordinated care organization; and

(4) Perform and do all acts that the authority deems necessary, advisable or expedient.

SECTION 31. (1) A court may make an order declaring a coordinated care organization insolvent at the time it grants an order of liquidation or at any time during the liquidation proceedings. When the order is issued, the Oregon Health Authority shall provide notice, in the manner determined by the court, to all persons who may have claims against the coordinated care organization and who have not filed proper proofs of their claims. The notice must instruct the persons to present their claims to the authority, at a specified place, within four months from the date of the entry of the insolvency order or within a longer time as the court prescribes. The notice must specify the last day that persons may file proofs of claims.

(2) A claimant filing a proof of claim after the last day specified for filing a claim may share in the distribution of the assets after all allowed claims for which proofs were timely filed are paid in full.

SECTION 32. (1) The circuit court shall have original jurisdiction of delinquency proceedings, and any court with jurisdiction is authorized to make all necessary or proper orders to carry out the purposes of sections 23 to 52 of this 2019 Act.

(2) The venue of delinquency proceedings and proceedings under sections 23 to 52 of this 2019 Act against a coordinated care organization shall be in the Circuit Court for Marion County.

(3) At any time after the commencement of a delinquency proceeding or a proceeding under sections 23 to 52 of this 2019 Act, the court may issue an order changing the venue of the proceeding on motion of the Oregon Health Authority or other interested person if the court finds the proceedings may be more economically and efficiently conducted thereby.

SECTION 33. (1) Delinquency proceedings constitute the sole and exclusive method of rehabilitating, liquidating or conserving a coordinated care organization, and a court may not entertain a petition for the commencement of such proceedings, or any other similar procedure, unless the Oregon Health Authority has filed such a petition in the name of the state.

(2) A coordinated care organization shall appeal an order granting or refusing rehabilitation, liquidation or conservation and every order in delinquency proceedings that has the character of a final order to the Court of Appeals.

SECTION 34. (1) The Oregon Health Authority shall commence a delinquency proceeding by an application to the court for an order directing the coordinated care organization to show cause why the authority should not have the relief prayed for.

(2) The application shall be by petition, verified by the authority, setting forth the ground or grounds for the proceeding and the relief demanded.

(3) If the court is satisfied from reading the authority's petition that the facts alleged, if established, would constitute grounds for a delinquency proceeding, the court shall issue an order to the coordinated care organization to show cause.

(4) On the return of the order to show cause, and after a full hearing, the court shall either deny the application or grant the application, together with such other relief as the nature of the case and the interests of the members of the coordinated care organization or the public may require.

(5) After commencement of a delinquency proceeding by the authority, the court may make any further orders necessary in response to the application of any interested person.

SECTION 35. (1) Upon application by the Oregon Health Authority for an order to show cause under section 34 of this 2019 Act, or at any time thereafter, the court may, without notice, issue an injunction restraining a coordinated care organization, its officers, members of its governing board, agents, employees and all other persons from the transaction of its business or the waste or disposition of its property until the further order of the court.

(2) The court may at any time during a delinquency proceeding issue other injunctions or orders to prevent any of the following activities:

(a) Transacting further business of the coordinated care organization.

(b) Transferring property.

(c) Interfering with the receiver or with a delinquency proceeding.

(d) Wasting assets of a coordinated care organization.

(e) Dissipating or transferring bank accounts.

(f) Instituting or further prosecuting any actions or proceedings.

(g) Obtaining preferences, judgments, attachments, garnishments or liens against the coordinated care organization or its assets.

(h) Levying execution against the coordinated care organization or its assets.

(i) The making of a sale or deed for nonpayment of taxes or assessments that would lessen the value of the assets of the coordinated care organization.

(j) Withholding from the receiver books, accounts, documents or other records relating to the business of the coordinated care organization.

(k) Taking any other threatened or contemplated action that might lessen the value of the assets of the coordinated care organization or prejudice the rights of the state, creditors or other interested persons, or the administration of a delinquency proceeding.

(3) Notwithstanding any other provision of law, the authority may not be required to post bond as a prerequisite for issuing any injunction or restraining order pursuant to this section.

SECTION 36. (1) The following persons are entitled to protection under this section:

(a) All receivers responsible for the conduct of a delinquency proceeding under sections 23 to 52 of this 2019 Act, including present and former receivers.

(b) All employees of the receiver described in paragraph (a) of this subsection. For purposes of this section, such employees include all present and former special deputies and assistant special deputies appointed by the Oregon Health Authority and all persons whom the authority, special deputies or assistant special deputies have employed to assist in a delinquency proceeding. Unless designated as special deputies, attorneys, accountants, auditors and other professional persons or firms who are retained by the receiver as independent contractors and their employees are not entitled to protection under this section.

(2) The receiver and employees of the receiver shall have official immunity and shall be immune from civil action and liability, both personally and in their official capacities, for any tort claim or demand, whether groundless or otherwise, arising out of any alleged act, error or omission of the receiver or any employee occurring in the performance of duties. For purposes of this section, "tort" has the meaning given that term in ORS 30.260.

(3) The receiver and employees of the receiver shall be indemnified from the assets of the coordinated care organization against any tort claim arising out of any alleged act, error or omission of the receiver or any employee occurring in the performance of duties, whether personally or in the official capacity of the receiver or employee. Any indemnification made under this subsection is an administrative expense of the coordinated care organization.

(4) The provisions of subsections (2) and (3) of this section do not apply in case of malfeasance in office or willful or wanton neglect of duty.

(5) In any legal action in which the receiver is a defendant, the portion of any settlement relating to the alleged act, error or omission of the receiver is subject to the approval of the court before which the delinquency proceeding is pending. The court may not approve the portion of the settlement if it determines:

(a) That the claim did not occur in the performance of the receiver's duties; or

(b) That the claim was caused by malfeasance in office or willful or wanton neglect of duty by the receiver.

(6) This section may not be construed or applied to deprive the receiver or any employee of any immunity, indemnity, benefits of law, rights or any defense otherwise available.

SECTION 37. The Oregon Health Authority, in connection with supervising a coordinated care organization or conducting a delinquency proceeding, may appoint one or more special deputy directors to act for the authority and may employ counsel, clerks and assistants as the authority deems necessary. Unless otherwise provided by the authority, a person so appointed is not a state employee solely by reason of the appointment. The compensation of the special deputies, counsel, clerks or assistants and all expenses of supervising the coordinated care organization or taking possession of a delinquent coordinated care organization and conducting delinquency proceedings must be paid out of the funds or assets of the coordinated care organization. A special deputy acting within limits the authority imposes with respect to supervising a coordinated care organization or conducting delinquency proceedings has a receiver's powers and is subject to a receiver's duties.

SECTION 38. (1) All claims against a coordinated care organization against which delinquency proceedings have been begun shall:

(a) Set forth in reasonable detail:

(A) The amount of the claim or the basis upon which the amount can be ascertained;

(B) The facts upon which the claim is based; and

(C) The priorities asserted, if any;

(b) Be verified by the affidavit of the claimant or someone authorized to act on behalf of the claimant and having knowledge of the facts; and

(c) Be supported by documentation.

(2) All claims shall be filed with the receiver on or before the last date for filing as specified in section 31 of this 2019 Act.

(3) After the expiration of any period for filing of claims, the receiver shall report the claims timely filed to the court, with recommendations for the actions to be taken by the

court. Upon receipt of the report, the court shall fix a time for hearing the claims and shall direct the claimants or the receiver, as specified by the court, to give notice to interested persons, in the manner determined by the court, of the time and place of the hearing, the amount and nature of the claim, the priorities asserted, if any, and the recommendation of the receiver with respect to the claim.

(4) All interested persons shall be entitled to appear at the hearing, and the court shall enter an order allowing, allowing in part or disallowing the claim. The order is an appealable order.

SECTION 39. All claims that are preferred under the laws of the state, whether owing to residents or nonresidents, shall be given equal priority of payment from the general assets of a coordinated care organization in a delinquency proceeding against the coordinated care organization regardless of where the assets are located.

SECTION 40. During the pendency of a delinquency proceeding against a coordinated care organization, an action or proceeding to obtain an attachment, garnishment or execution may not be commenced or maintained in the courts of this state against the delinquent coordinated care organization or its assets. An attachment, garnishment or execution obtained prior to the commencement of a delinquency proceeding or at any time thereafter shall be void as against any rights arising in the delinquency proceeding unless the attachment, garnishment or execution obtained by the action or proceeding was obtained more than four months prior to the commencement of the delinquency proceeding.

SECTION 41. (1) A transfer of or lien upon the property of a coordinated care organization, other than as provided in section 40 of this 2019 Act, is voidable if the transfer or lien is:

(a) Made or created within four months prior to the commencement of a delinquency proceeding;

(b) Made with the intent of giving to a transferee or lienor or enabling the transferee or lienor to obtain a greater percentage of the debt than any other creditor of the same class; and

(c) Accepted by a transferee or lienor who has reasonable cause to believe that the transferee or lienor will obtain a greater percentage of the debt than any other creditor of the same class.

(2) Every director, officer, employee or other person acting on behalf of a coordinated care organization who participates in a transfer or lien described in subsection (1) of this section, and every person receiving any property of the coordinated care organization or the benefit of the transfer or lien, shall be personally liable as described in subsection (3) of this section.

(3) The Oregon Health Authority, as a receiver in a delinquency proceeding, may avoid any transfer of, or lien upon, the property of a coordinated care organization described in subsection (1) of this section and may recover the property or value of the property transferred or attached unless the person in possession of the property or the lien was a bona fide holder for value prior to the commencement of the delinquency proceeding.

SECTION 42. Except as provided in section 47 of this 2019 Act for secured claims, the claims to be paid in full in delinquency proceedings against a coordinated care organization prior to the payment of any other claims, and the order of payment, shall be:

(1) The expenses of administering the delinquency proceedings;

(2) Claims that are legally due and owing by the coordinated care organization to the United States;

(3) Compensation or wages owed to employees other than officers of the coordinated care organization, for services rendered within three months prior to the commencement of the delinquency proceeding, but not exceeding $2,000 for each employee;

(4) Claims legally due and owed by the coordinated care organization to the state; and

(5) Claims, including special deposit claims, owed to any person that by the laws of the state is entitled to priority.

SECTION 43. Offsets may not be allowed in cases of mutual debts or mutual credits between the coordinated care organization and another person in connection with a delinquency proceeding, except with respect to reinsurance.

SECTION 44. (1) A contingent claim against a coordinated care organization shall be filed, presented and reported in the same manner and within the same time limitations as provided in section 31 of this 2019 Act for a noncontingent claim. Contingent claims shall be allowed to share in a distribution of assets in the same manner as noncontingent claims of the same class and priority, provided that the contingent claim becomes an absolute claim either as a result of proof presented or litigation.

(2) Nothing in subsection (1) of this section prevents or bars the Oregon Health Authority from compromising a disputed claim with a claimant, whether contingent or noncontingent, if the compromise is justified and supported by the facts and circumstances.

(3) If full or partial distribution to noncontingent claimants is authorized or directed by the court prior to satisfaction of the requirements of subsection (1) of this section, the authority shall retain a sum equal to the amount that would have been paid on the contingent claims if the requirements in subsection (1) of this section had been met. The amount withheld shall be distributed to the person or persons found by the court to be entitled to a distribution when:

(a) The contingent claims are fully established as provided in subsection (1) of this section; or

(b) The authority is satisfied that the contingent claims are without merit or cannot be proved or established, or the statute of limitations would bar further consideration or recovery on the claim.

(4)(a) A judgment entered after the commencement of a delinquency proceeding is conclusive evidence in the liquidation proceeding, either of liability or of the amount of damages.

(b) A judgment entered after the date of entry of a liquidation order may not be considered in the liquidation proceedings as evidence of liability or of the amount of damages.

SECTION 45. (1) Whenever a receiver is to be appointed in delinquency proceedings for a coordinated care organization, the court shall appoint the Oregon Health Authority as the receiver. The court shall direct the receiver to take possession of the property of the coordinated care organization and to administer the property as ordered by the court.

(2) Any deed or other instrument executed in a delinquency proceeding or by an order of liquidation shall be valid and effectual for all purposes as though the same had been executed by the person affected by any proceedings or by the officers of the coordinated care organization pursuant to the direction of its governing board. A record of the order directing possession to be taken, or a certified copy of the order, filed in the office where instruments affecting title to property are required to be filed or recorded, shall have the same effect as

the filing or recording of a deed, bill of sale or other evidence of title.

(3) If any real property sold by the authority is located in a county other than the county where the proceeding is pending, the authority shall file a certified copy of the order of the appointment, or order authorizing or ratifying the sale, with the recording officer for the county where the property is located.

(4) The authority as receiver shall be responsible on the official bond of the authority for the proper administration of all property coming into the possession or control of the authority. The court may at any time require an additional bond from the authority or the deputies of the authority if deemed desirable for the protection of the property.

SECTION 46. The owners of special deposit claims against a coordinated care organization for which a receiver is appointed shall be given priority against their several special deposits in accordance with the provisions of the statutes governing the creation and maintenance of the deposits. If there is a deficiency in any deposit so that claims secured by the deposit are not fully discharged, the claimants may share in the general assets of the coordinated care organization after:

(1) The payment of claims of general creditors; and

(2) Claimants against other special deposits, who have received smaller percentages from their respective special deposits, have been paid percentages of their claims equal to the percentage paid from the special deposit.

SECTION 47. The owner of a secured claim against a coordinated care organization for which a receiver has been appointed may surrender the security and file a claim as a general creditor, or the claim may be discharged by resort to the security, in which case the deficiency, if any, shall be treated as a claim against the general assets of the coordinated care organization on the same basis as claims of unsecured creditors.

SECTION 48. Notwithstanding ORS 37.040, the Oregon Receivership Code does not apply to delinquency proceedings under sections 23 to 52 of this 2019 Act

SECTION 49. The Oregon Health Authority may apply for an order directing the authority to liquidate the business of a coordinated care organization, regardless of whether there has been a prior order directing the authority to rehabilitate the coordinated care organization, upon any of the grounds specified in section 27 of this 2019 Act, or if the coordinated care organization:

(1) Has ceased transacting business for a period of one year;

(2) Under any laws except sections 23 to 52 of this 2019 Act or rules adopted pursuant to section 53 of this 2019 Act, has:

(a) Commenced voluntary liquidation or dissolution;

(b) Attempted to commence or prosecute an action or proceeding to liquidate its business or affairs;

(c) Commenced dissolving its corporate charter; or

(d) Commenced procuring the appointment of a receiver, trustee, custodian, or sequestrator; or

(3) Is insolvent.

SECTION 50. The rights and liabilities of the coordinated care organization, its creditors and all other persons interested in its assets shall, unless otherwise directed by the court, be fixed as of the date on which an order directing the liquidation of the coordinated care organization is filed in the office of the clerk of the court that made the order, subject to

the provisions of section 44 of this 2019 Act with respect to the rights of claimants holding contingent claims.

SECTION 51. (1) An order to liquidate the business of a coordinated care organization shall direct the Oregon Health Authority to:

(a) Take possession of the property of the coordinated care organization;

(b) Liquidate the business of the coordinated care organization;

(c) Deal with the coordinated care organization's property and business in the name of the authority or in the name of the coordinated care organization as the court may direct; and

(d) Give notice to all creditors who may have claims against the coordinated care organization to present such claims.

(2) The authority may apply to the court for an order dissolving the corporate existence of a coordinated care organization at the time the authority applies for an order to liquidate or at any time after an order to liquidate has been granted.

SECTION 52. (1) For the purpose of this section only, and only in the event of a finding of impairment by the Oregon Health Authority, as described in section 26 of this 2019 Act, or of a final order of liquidation, any covered health care service furnished within this state by a provider to a member of a coordinated care organization shall be considered to have been furnished pursuant to a contract between the provider and the coordinated care organization with whom the member was enrolled when the services were furnished.

(2) Each contract between a coordinated care organization and a provider of health care services shall provide that if the coordinated care organization fails to pay for covered health care services as set forth in the coordinated care organization's contract with the authority, the member is not liable to the provider for any amounts owed by the coordinated care organization.

(3) If the contract between the contracting provider and the coordinated care organization has not been reduced to writing or fails to contain the provisions required by subsection (2) of this section, the member is not liable to the contracting provider for any amounts owed by the coordinated care organization.

(4) A contracting provider or agent, trustee or assignee of the contracting provider may not maintain a civil action against a member to collect any amounts owed by the coordinated care organization for which the member is not liable to the contracting provider under this section.

(5) Nothing in this section impairs the right of a provider to charge, collect from, attempt to collect from or maintain a civil action against a member for any of the following:

(a) Health care services not covered by the medical assistance program.

(b) Health care services rendered after the termination of the contract between the coordinated care organization and the provider, unless the health care services were rendered during the confinement in an inpatient facility and the confinement began prior to the date of termination or unless the provider has assumed post-termination treatment obligations under the contract.

(6) Nothing in this section prohibits a member from seeking noncovered health care services from a provider and accepting financial responsibility for these services.

(7) A coordinated care organization may not limit the right of a provider of health care services to contract with the patient for payment of services not within the scope of cover-

age under the medical assistance program.

SECTION 53. (1) The Oregon Health Authority may adopt rules to carry out the provisions of sections 1 to 52 of this 2019 Act.

(2) The authority shall adopt rules for regulating the financial solvency of coordinate care organizations that align with the following provisions of the Insurance Code regulating domestic insurers, to the extent the provisions regarding insurers are applicable to coordinated care organizations and are in accordance with ORS chapters 413 and 414:

(a) ORS 731.385;

(b) ORS 731.488;

(c) ORS 731.504;

(d) ORS 731.508;

(e) ORS 731.509 (1) to (8) and (10);

(f) ORS 731.574 (1) to (5);

(g) ORS 731.988;

(h) ORS 732.235;

(i) ORS 732.517 to 732.546, other than ORS 732.527, 732.531 and 732.541;

(j) ORS 732.549;

(k) ORS 732.551;

(L) ORS 732.552;

(m) ORS 732.553;

(n) ORS 732.554;

(o) ORS 732.556;

(p) ORS 732.558;

(q) ORS 732.564;

(r) ORS 732.566

(s) ORS 732.567;

(t) ORS 732.568;

(u) ORS 732.569;

(v) ORS 732.574;

(w) ORS 732.576;

(x) ORS 732.578;

(y) ORS 733.010 to 733.050;

(z) ORS 733.140 to 733.170;

(aa) ORS 733.510 to 733.680; and

(bb) ORS 733.695 to 733.780.

SECTION 54. ORS 413.032 is amended to read:

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

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

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

(c) Administer the Oregon Prescription Drug Program;

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

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

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

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

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

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

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

(A) Review of administrative expenses of health insurers;

(B) Approval of rates; and

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

(k) Structure reimbursement rates for providers that serve recipients of medical assistance to reward comprehensive management of diseases, quality outcomes and the efficient use of resources and to promote cost-effective procedures, services and programs including, without limitation, preventive health, dental and primary care services, web-based office visits, telephone consultations and telemedicine consultations;

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

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

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

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

(2) The Oregon Health Authority is authorized to:

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

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

(A) Uniform quality standards and performance measures;

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

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

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

(3) The enumeration of duties, functions and powers in this section is not intended to be exclusive nor to limit the duties, functions and powers imposed on or vested in the Oregon Health Authority by ORS 413.006 to 413.042 and 741.340 **and sections 1 to 52 of this 2019 Act** or by other statutes.

SECTION 55. ORS 413.037 is amended to read:

413.037. (1) The Director of the Oregon Health Authority, each deputy director and authorized representatives of the director may administer oaths, take depositions and issue subpoenas to compel the attendance of witnesses and the production of documents or other written information necessary to carry out the provisions of ORS 413.006 to 413.042 and 741.340 **and sections 1 to 52 of this 2019 Act**.

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

SECTION 56. ORS 413.181 is amended to read:

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

(2) The authority may use information disclosed under subsection (1) of this section for the purpose of carrying out ORS 413.032, 414.625, 414.635, 414.638, 414.645 and 414.651 **and sections 1 to 52 of this 2019 Act**.

SECTION 57. 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*]**, capital or surplus, or any combination of the three, in amounts necessary to ensure the solvency of the coordinated care organization, as specified by the authority by rules that are consistent with ORS 731.554 (1) and (6), 732.225, 733.080 and 750.045**.

(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 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 58. 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*]**, capital or surplus, or any combination of the three, in amounts necessary to ensure the solvency of the coordinated care organization, as specified by the authority by rules that are consistent with ORS 731.554 (1) and (6), 732.225, 733.080 and 750.045**.

(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.

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