

SB 735-1
(LC 3509)
3/28/19 (LHF/ps)

Requested by Senator STEINER HAYWARD

**PROPOSED AMENDMENTS TO
SENATE BILL 735**

1 On page 1 of the printed bill, line 2, after “ORS” delete the rest of the
2 line and line 3 and insert “243.135, 243.866, 413.017, 413.032, 414.025, 414.065,
3 414.625, 414.638, 414.652, 417.721 and 743B.200 and sections 1 and 3, chapter
4 389, Oregon Laws 2015, and section 2, chapter 575, Oregon Laws 2015.”.

5 Delete lines 5 through 28 and delete pages 2 through 4 and insert:

6 **“SECTION 1.** ORS 413.017 is amended to read:

7 “413.017. (1) The Oregon Health Policy Board shall establish the commit-
8 tees described in subsections (2) to (4) of this section.

9 “(2)(a) The Public Health Benefit Purchasers Committee shall include in-
10 dividuals who purchase health care for the following:

11 “(A) The Public Employees’ Benefit Board.

12 “(B) The Oregon Educators Benefit Board.

13 “(C) Trustees of the Public Employees Retirement System.

14 “(D) A city government.

15 “(E) A county government.

16 “(F) A special district.

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

19 “(b) The Public Health Benefit Purchasers Committee shall:

20 “(A) Identify and make specific recommendations to achieve uniformity
21 across all public health benefit plan designs based on the best available

1 clinical evidence, recognized best practices for health promotion and disease
2 management, demonstrated cost-effectiveness and shared demographics
3 among the enrollees within the pools covered by the benefit plans.

4 “(B) Develop an action plan for ongoing collaboration to implement the
5 benefit design alignment described in subparagraph (A) of this paragraph and
6 shall leverage purchasing to achieve benefit uniformity if practicable.

7 “(C) Continuously review and report to the Oregon Health Policy Board
8 on the committee’s progress in aligning benefits while minimizing the cost
9 shift to individual purchasers of insurance without shifting costs to the pri-
10 vate sector or the health insurance exchange.

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

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

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

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

1 “(4)(a) The Health [*Plan*] Quality Metrics Committee shall include the
2 following members appointed by the Governor:

3 “(A) An individual representing the Oregon Health Authority;

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

5 “(C) An individual representing the Public Employees’ Benefit Board;

6 “(D) An individual representing the Department of Consumer and Busi-
7 ness Services;

8 “(E) Two health care providers;

9 “(F) One individual representing hospitals;

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

12 “(H) Two individuals representing health care consumers;

13 “(I) Two individuals representing coordinated care organizations;

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

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

16 [*and*]

17 “(L) One individual with expertise in mental health and addiction
18 services;

19 “(M) **One individual with expertise in oral health and dental care;**

20 “(N) **One individual who represents rural hospitals; and**

21 “(O) **One individual who represents insurers who offer health ben-
22 efit plans to small employers.**

23 “(b) The committee shall work collaboratively with the Oregon Educators
24 Benefit Board, the Public Employees’ Benefit Board, the Oregon Health Au-
25 thority and the Department of Consumer and Business Services to adopt
26 [*health outcome and quality*] measures **of health outcomes and health care**
27 **quality** that are focused on specific goals and provide value to the state,
28 employers, insurers, health care providers and consumers. The committee
29 shall be the single body to align [*health outcome and quality*] measures **of**
30 **health outcomes and health care quality** used in this state with the re-

1 requirements of health care data reporting to ensure that the measures and
2 requirements are coordinated, evidence-based and focused on a long term
3 statewide vision.

4 “(c)(A) The committee shall use a public process that includes an oppor-
5 tunity for public comment to identify [*health outcome and quality measures*
6 *that may be applied to services provided by coordinated care organizations or*
7 *paid for by health benefit plans sold through the health insurance exchange*
8 *or offered by the Oregon Educators Benefit Board or the Public Employees’*
9 *Benefit Board.*] **measures of health outcomes and health care quality**
10 **applicable to:**

11 “(i) **Health care provided by coordinated care organizations;**

12 “(ii) **Inpatient and outpatient services provided by hospitals; and**

13 “(iii) **Health care paid for by health benefit plans sold in this state.**

14 “(B) **The committee shall identify the category of services to which**
15 **each measure applies and may recommend a core set of measures to**
16 **be adopted for all categories.**

17 “(C) The Oregon Health Authority, the Department of Consumer and
18 Business Services, the Oregon Educators Benefit Board and the Public
19 Employees’ Benefit Board are not required to adopt all of the [*health outcome*
20 *and quality*] measures **of health outcomes and health care quality** iden-
21 tified by the committee **for their own use** but may not adopt any [*health*
22 *outcome and quality*] measures **of health outcomes and health care qual-**
23 **ity** that are different from the measures identified by the committee.

24 “(D) The measures must take into account the recommendations of the
25 metrics and scoring subcommittee created in ORS 414.638 and the differences
26 in the populations served by coordinated care organizations and by commer-
27 cial insurers.

28 “(d) In identifying [*health outcome and quality*] measures **of health out-**
29 **comes and health care quality**, the committee shall prioritize measures
30 that:

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

5 “(B) [*Given the context in which each measure is applied, are not prone to*
6 *random variations based on the size of the denominator*] **Are likely to gen-**
7 **erate valid and reliable results;**

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

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

12 “(E) Use a common format in the collection of the data and facilitate the
13 public reporting of the data; [*and*]

14 “(F) Can be reported in a timely manner and without significant delay so
15 that the most current and actionable data is available; **and**

16 “(G) **Align with statewide strategic goals for the improvement of**
17 **health and health care.**

18 “(e) The committee shall evaluate on a regular and ongoing basis the
19 [*health outcome and quality*] measures **of health outcomes and health care**
20 **quality** adopted under this section.

21 “(f) The committee may convene subcommittees to focus on gaining ex-
22 pertise in particular areas such as data collection, health care research and
23 mental health and substance use disorders in order to aid the committee in
24 the development of [*health outcome and quality*] measures **of health out-**
25 **comes and health care quality.** A subcommittee may include stakeholders
26 and staff from the Oregon Health Authority, the Department of Human Ser-
27 vices, the Department of Consumer and Business Services, the Early Learn-
28 ing Council or any other agency staff with the appropriate expertise in the
29 issues addressed by the subcommittee.

30 “(g) This subsection does not prevent the Oregon Health Authority, the

1 Department of Consumer and Business Services, commercial insurers, the
2 Public Employees' Benefit Board or the Oregon Educators Benefit Board
3 from establishing programs that provide financial incentives to providers for
4 meeting specific [*health outcome and quality*] measures **of health outcomes**
5 **and health care quality** adopted by the committee.

6 “(5) Members of the committees described in subsections (2) to (4) of this
7 section who are not members of the Oregon Health Policy Board are not
8 entitled to compensation but shall be reimbursed from funds available to the
9 board for actual and necessary travel and other expenses incurred by them
10 by their attendance at committee meetings, in the manner and amount pro-
11 vided in ORS 292.495.

12 **“SECTION 2.** ORS 743B.200 is amended to read:

13 “743B.200. Each [*insurer*] **carrier** offering [*managed health insurance*] a
14 **health benefit plan** in this state shall:

15 “(1) Have a quality assessment program that enables the insurer to eval-
16 uate, maintain and improve the quality of health services provided to
17 enrollees **and the health outcomes of enrollees using, at a minimum,**
18 **the measures adopted by the Health Quality Metrics Committee under**
19 **ORS 413.017 (4)(c).** The program shall include data gathering that allows the
20 plan to measure progress on specific quality improvement goals chosen by
21 the insurer.

22 “(2) File an annual summary with the Department of Consumer and
23 Business Services that describes quality assessment activities, including any
24 activities related to credentialing of providers, and reports any progress on
25 the insurer's quality improvement goals.

26 “(3) File annually with the department the following information:

27 “(a) Results of all publicly available federal Centers for Medicare and
28 Medicaid Services reports and accreditation surveys by national accredi-
29 tation organizations.

30 “(b) The insurer's health promotion and disease prevention activities, if

1 any, including a summary of screening and preventive health care activities
2 covered by the insurer.

3 **“SECTION 3.** ORS 243.135 is amended to read:

4 “243.135. (1) Notwithstanding any other benefit plan contracted for and
5 offered by the Public Employees’ Benefit Board, the board shall contract for
6 a health benefit plan or plans best designed to meet the needs and provide
7 for the welfare of eligible employees, the state and the local governments.
8 In considering whether to enter into a contract for a plan, the board shall
9 place emphasis on:

- 10 “(a) Employee choice among high quality plans;
- 11 “(b) A competitive marketplace;
- 12 “(c) Plan performance and information;
- 13 “(d) Employer flexibility in plan design and contracting;
- 14 “(e) Quality customer service;
- 15 “(f) Creativity and innovation;
- 16 “(g) Plan benefits as part of total employee compensation;
- 17 “(h) The improvement of employee health; and
- 18 “(i) [*Health outcome and quality measures*] **Measures of health out-**
19 **comes and health care quality**, described in ORS 413.017 (4), that are re-
20 ported by the plan.

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

25 “(3) Where appropriate for a contracted and offered health benefit plan,
26 the board shall provide options under which an eligible employee may ar-
27 range coverage for family members.

28 “(4) Payroll deductions for costs that are not payable by the state or a
29 local government may be made upon receipt of a signed authorization from
30 the employee indicating an election to participate in the plan or plans se-

1 lected and the deduction of a certain sum from the employee's pay.

2 “(5) In developing any health benefit plan, the board may provide an op-
3 tion of additional coverage for eligible employees and their family members
4 at an additional cost or premium.

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

14 “(7) The board shall evaluate a benefit plan that serves a limited ge-
15 ographic region of this state according to the criteria described in subsection
16 (1) of this section.

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

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

24 **“SECTION 4.** ORS 243.135, as amended by section 27, chapter 746, Oregon
25 Laws 2017, is amended to read:

26 “243.135. (1) Notwithstanding any other benefit plan contracted for and
27 offered by the Public Employees' Benefit Board, the board shall contract for
28 a health benefit plan or plans best designed to meet the needs and provide
29 for the welfare of eligible employees, the state and the local governments.
30 In considering whether to enter into a contract for a plan, the board shall

1 place emphasis on:

2 “(a) Employee choice among high quality plans;

3 “(b) A competitive marketplace;

4 “(c) Plan performance and information;

5 “(d) Employer flexibility in plan design and contracting;

6 “(e) Quality customer service;

7 “(f) Creativity and innovation;

8 “(g) Plan benefits as part of total employee compensation;

9 “(h) The improvement of employee health; and

10 “(i) [*Health outcome and quality measures*] **Measures of health out-**
11 **comes and health care quality**, described in ORS 413.017 (4), that are re-
12 ported by the plan.

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

17 “(3) Where appropriate for a contracted and offered health benefit plan,
18 the board shall provide options under which an eligible employee may ar-
19 range coverage for family members who are not enrolled in another health
20 benefit plan offered by the board or the Oregon Educators Benefit Board.
21 An eligible employee who declines coverage in a health benefit plan offered
22 by the Public Employees’ Benefit Board or the Oregon Educators Benefit
23 Board and who is enrolled as a spouse or family member in another health
24 benefit plan offered by the Public Employees’ Benefit Board or the Oregon
25 Educators Benefit Board may not be paid the employer contribution for the
26 plan that was declined.

27 “(4) Payroll deductions for costs that are not payable by the state or a
28 local government may be made upon receipt of a signed authorization from
29 the employee indicating an election to participate in the plan or plans se-
30 lected and the deduction of a certain sum from the employee’s pay.

1 “(5) In developing any health benefit plan, the board may provide an op-
2 tion of additional coverage for eligible employees and their family members
3 at an additional cost or premium.

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

13 “(7) The board shall evaluate a benefit plan that serves a limited ge-
14 ographic region of this state according to the criteria described in subsection
15 (1) of this section.

16 “(8)(a) The board shall use payment methodologies in self-insured health
17 benefit plans offered by the board that are designed to limit the growth in
18 per-member expenditures for health services to no more than 3.4 percent per
19 year.

20 “(b) The board shall adopt policies and practices designed to limit the
21 annual increase in premium amounts paid for contracted health benefit plans
22 to 3.4 percent.

23 “(9) A carrier or third party administrator that contracts with the board
24 to provide or administer a health benefit plan shall, at least once each plan
25 year, conduct an audit of the health benefit plan enrollees’ continued eligi-
26 bility for coverage as spouses or dependents or any other basis that would
27 affect the cost of the premium for the plan.

28 “(10) By January 1, 2023, the board shall spend at least 12 percent of its
29 total medical expenditures in self-insured health benefit plans on payments
30 for primary care.

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

5 “**SECTION 5.** ORS 243.135, as amended by section 16, chapter 489, Oregon
6 Laws 2017, and section 27, chapter 746, Oregon Laws 2017, is amended to
7 read:

8 “243.135. (1) Notwithstanding any other benefit plan contracted for and
9 offered by the Public Employees’ Benefit Board, the board shall contract for
10 a health benefit plan or plans best designed to meet the needs and provide
11 for the welfare of eligible employees, the state and the local governments.
12 In considering whether to enter into a contract for a plan, the board shall
13 place emphasis on:

14 “(a) Employee choice among high quality plans;

15 “(b) A competitive marketplace;

16 “(c) Plan performance and information;

17 “(d) Employer flexibility in plan design and contracting;

18 “(e) Quality customer service;

19 “(f) Creativity and innovation;

20 “(g) Plan benefits as part of total employee compensation;

21 “(h) The improvement of employee health; and

22 “(i) [*Health outcome and quality measures*] **Measures of health out-**
23 **comes and health care quality**, described in ORS 413.017 (4), that are re-
24 ported by the plan.

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

29 “(3) Where appropriate for a contracted and offered health benefit plan,
30 the board shall provide options under which an eligible employee may ar-

1 range coverage for family members who are not enrolled in another health
2 benefit plan offered by the board or the Oregon Educators Benefit Board.
3 An eligible employee who declines coverage in a health benefit plan offered
4 by the Public Employees' Benefit Board or the Oregon Educators Benefit
5 Board and who is enrolled as a spouse or family member in another health
6 benefit plan offered by the Public Employees' Benefit Board or the Oregon
7 Educators Benefit Board may not be paid the employer contribution for the
8 plan that was declined.

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

13 “(5) In developing any health benefit plan, the board may provide an op-
14 tion of additional coverage for eligible employees and their family members
15 at an additional cost or premium.

16 “(6) Transfer of enrollment from one plan to another shall be open to all
17 eligible employees and their family members under rules adopted by the
18 board. Because of the special problems that may arise in individual instances
19 under comprehensive group practice plan coverage involving acceptable
20 provider-patient relations between a particular panel of providers and par-
21 ticular eligible employees and their family members, the board shall provide
22 a procedure under which any eligible employee may apply at any time to
23 substitute a health service benefit plan for participation in a comprehensive
24 group practice benefit plan.

25 “(7) The board shall evaluate a benefit plan that serves a limited ge-
26 ographic region of this state according to the criteria described in subsection
27 (1) of this section.

28 “(8)(a) The board shall use payment methodologies in self-insured health
29 benefit plans offered by the board that are designed to limit the growth in
30 per-member expenditures for health services to no more than 3.4 percent per

1 year.

2 “(b) The board shall adopt policies and practices designed to limit the
3 annual increase in premium amounts paid for contracted health benefit plans
4 to 3.4 percent.

5 “(9) A carrier or third party administrator that contracts with the board
6 to provide or administer a health benefit plan shall, at least once each plan
7 year, conduct an audit of the health benefit plan enrollees’ continued eligi-
8 bility for coverage as spouses or dependents or any other basis that would
9 affect the cost of the premium for the plan.

10 “(10) If the board spends less than 12 percent of its total medical ex-
11 penditures in self-insured health benefit plans on payments for primary care,
12 the board shall implement a plan for increasing the percentage of total
13 medical expenditures spent on payments for primary care by at least one
14 percent each year.

15 “(11) No later than February 1 of each year, the board shall report to the
16 Legislative Assembly on any plan implemented under subsection (10) of this
17 section and on the board’s progress toward achieving the target of spending
18 at least 12 percent of total medical expenditures in self-insured health benefit
19 plans on payments for primary care.

20 **“SECTION 6.** ORS 243.866 is amended to read:

21 “243.866. (1) The Oregon Educators Benefit Board shall contract for ben-
22 efit plans best designed to meet the needs and provide for the welfare of el-
23 igible employees, the districts and local governments. In considering whether
24 to enter into a contract for a benefit plan, the board shall place emphasis
25 on:

26 “(a) Employee choice among high-quality plans;

27 “(b) Encouragement of a competitive marketplace;

28 “(c) Plan performance and information;

29 “(d) District and local government flexibility in plan design and con-
30 tracting;

1 “(e) Quality customer service;
2 “(f) Creativity and innovation;
3 “(g) Plan benefits as part of total employee compensation;
4 “(h) Improvement of employee health; and
5 “(i) [*Health outcome and quality measures*] **Measures of health out-**
6 **comes and health care quality**, described in ORS 413.017 (4), that are re-
7 ported by the plan.

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

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

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

19 “(5) In developing any benefit plan, the board may provide an option of
20 additional coverage for eligible employees and family members at an addi-
21 tional premium.

22 “(6) The board shall adopt rules providing that transfer of enrollment
23 from one benefit plan to another is open to all eligible employees and family
24 members. Because of the special problems that may arise involving accepta-
25 ble provider-patient relations between a particular panel of providers and a
26 particular eligible employee or family member under a comprehensive group
27 practice benefit plan, the board shall provide a procedure under which any
28 eligible employee may apply at any time to substitute another benefit plan
29 for participation in a comprehensive group practice benefit plan.

30 “(7) An eligible employee who is retired is not required to participate in

1 a health benefit plan offered under this section in order to obtain dental
2 benefit plan coverage. The board shall establish by rule standards of eligi-
3 bility for retired employees to participate in a dental benefit plan.

4 “(8) The board shall evaluate a benefit plan that serves a limited ge-
5 ographic region of this state according to the criteria described in subsection
6 (1) of this section.

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

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

14 **“SECTION 7.** ORS 243.866, as amended by section 28, chapter 746, Oregon
15 Laws 2017, is amended to read:

16 “243.866. (1) The Oregon Educators Benefit Board shall contract for ben-
17 efit plans best designed to meet the needs and provide for the welfare of el-
18 igible employees, the districts and local governments. In considering whether
19 to enter into a contract for a benefit plan, the board shall place emphasis
20 on:

21 “(a) Employee choice among high-quality plans;

22 “(b) Encouragement of a competitive marketplace;

23 “(c) Plan performance and information;

24 “(d) District and local government flexibility in plan design and con-
25 tracting;

26 “(e) Quality customer service;

27 “(f) Creativity and innovation;

28 “(g) Plan benefits as part of total employee compensation;

29 “(h) Improvement of employee health; and

30 “(i) [*Health outcome and quality measures*] **Measures of health out-**

1 **comes and health care quality**, described in ORS 413.017 (4), that are re-
2 ported by the plan.

3 “(2) The board may approve more than one carrier for each type of benefit
4 plan offered, but the board shall limit the number of carriers to a number
5 consistent with adequate service to eligible employees and family members
6 who are not enrolled in another health benefit plan offered by the board or
7 the Public Employees’ Benefit Board. An eligible employee who declines
8 coverage in a health benefit plan offered by the Oregon Educators Benefit
9 Board or the Public Employees’ Benefit Board and who is enrolled as a
10 spouse or family member in another health benefit plan offered by the
11 Oregon Educators Benefit Board or the Public Employees’ Benefit Board may
12 not be paid the employer contribution for the plan that was declined.

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

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

21 “(5) In developing any benefit plan, the board may provide an option of
22 additional coverage for eligible employees and family members at an addi-
23 tional premium.

24 “(6) The board shall adopt rules providing that transfer of enrollment
25 from one benefit plan to another is open to all eligible employees and family
26 members. Because of the special problems that may arise involving accepta-
27 ble provider-patient relations between a particular panel of providers and a
28 particular eligible employee or family member under a comprehensive group
29 practice benefit plan, the board shall provide a procedure under which any
30 eligible employee may apply at any time to substitute another benefit plan

1 for participation in a comprehensive group practice benefit plan.

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

6 “(8) The board shall evaluate a benefit plan that serves a limited ge-
7 ographic region of this state according to the criteria described in subsection
8 (1) of this section.

9 “(9)(a) The board shall use payment methodologies in self-insured health
10 benefit plans offered by the board that are designed to limit the growth in
11 per-member expenditures for health services to no more than 3.4 percent per
12 year.

13 “(b) The board shall adopt policies and practices designed to limit the
14 annual increase in premium amounts paid for contracted health benefit plans
15 to 3.4 percent.

16 “(10) A carrier or third party administrator that contracts with the board
17 to provide or administer a health benefit plan shall, at least once each plan
18 year, conduct an audit of the health benefit plan enrollees’ continued eligi-
19 bility for coverage as spouses or dependents or any other basis that would
20 affect the cost of the premium for the plan.

21 “(11) By January 1, 2023, the board shall spend at least 12 percent of its
22 total medical expenditures in self-insured health benefit plans on payments
23 for primary care.

24 “(12) No later than February 1 of each year, the board shall report to the
25 Legislative Assembly on the board’s progress toward achieving the target of
26 spending at least 12 percent of total medical expenditures on payments for
27 primary care.

28 **“SECTION 8.** ORS 243.866, as amended by section 17, chapter 489, Oregon
29 Laws 2017, and section 28, chapter 746, Oregon Laws 2017, is amended to
30 read:

1 “243.866. (1) The Oregon Educators Benefit Board shall contract for ben-
2 efit plans best designed to meet the needs and provide for the welfare of el-
3 igible employees, the districts and local governments. In considering whether
4 to enter into a contract for a benefit plan, the board shall place emphasis
5 on:

6 “(a) Employee choice among high-quality plans;

7 “(b) Encouragement of a competitive marketplace;

8 “(c) Plan performance and information;

9 “(d) District and local government flexibility in plan design and con-
10 tracting;

11 “(e) Quality customer service;

12 “(f) Creativity and innovation;

13 “(g) Plan benefits as part of total employee compensation;

14 “(h) Improvement of employee health; and

15 “(i) [*Health outcome and quality measures*] **Measures of health out-**
16 **comes and health care quality**, described in ORS 413.017 (4), that are re-
17 ported by the plan.

18 “(2) The board may approve more than one carrier for each type of benefit
19 plan offered, but the board shall limit the number of carriers to a number
20 consistent with adequate service to eligible employees and family members
21 who are not enrolled in another health benefit plan offered by the board or
22 the Public Employees’ Benefit Board. An eligible employee who declines
23 coverage in a health benefit plan offered by the Oregon Educators Benefit
24 Board or the Public Employees’ Benefit Board and who is enrolled as a
25 spouse or family member in another health benefit plan offered by the
26 Oregon Educators Benefit Board or the Public Employees’ Benefit Board may
27 not be paid the employer contribution for the plan that was declined.

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

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

6 “(5) In developing any benefit plan, the board may provide an option of
7 additional coverage for eligible employees and family members at an addi-
8 tional premium.

9 “(6) The board shall adopt rules providing that transfer of enrollment
10 from one benefit plan to another is open to all eligible employees and family
11 members. Because of the special problems that may arise involving accepta-
12 ble provider-patient relations between a particular panel of providers and a
13 particular eligible employee or family member under a comprehensive group
14 practice benefit plan, the board shall provide a procedure under which any
15 eligible employee may apply at any time to substitute another benefit plan
16 for participation in a comprehensive group practice benefit plan.

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

21 “(8) The board shall evaluate a benefit plan that serves a limited ge-
22 ographic region of this state according to the criteria described in subsection
23 (1) of this section.

24 “(9)(a) The board shall use payment methodologies in self-insured health
25 benefit plans offered by the board that are designed to limit the growth in
26 per-member expenditures for health services to no more than 3.4 percent per
27 year.

28 “(b) The board shall adopt policies and practices designed to limit the
29 annual increase in premium amounts paid for contracted health benefit plans
30 to 3.4 percent.

1 “(10) A carrier or third party administrator that contracts with the board
2 to provide or administer a health benefit plan shall, at least once each plan
3 year, conduct an audit of the health benefit plan enrollees’ continued eligi-
4 bility for coverage as spouses or dependents or any other basis that would
5 affect the cost of the premium for the plan.

6 “(11) If the board spends less than 12 percent of its total medical ex-
7 penditures in self-insured health benefit plans on payments for primary care,
8 the board shall implement a plan for increasing the percentage of total
9 medical expenditures spent on payments for primary care by at least one
10 percent each year.

11 “(12) No later than February 1 of each year, the board shall report to the
12 Legislative Assembly on any plan implemented under subsection (11) of this
13 section and on the board’s progress toward achieving the target of spending
14 at least 12 percent of total medical expenditures on payments for primary
15 care.

16 **“SECTION 9.** ORS 413.032 is amended to read:

17 “413.032. (1) The Oregon Health Authority is established. The authority
18 shall:

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

20 “(b) Administer the Oregon Integrated and Coordinated Health Care De-
21 livery System established in ORS 414.620;

22 “(c) Administer the Oregon Prescription Drug Program;

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

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

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

29 “(g) Provide regular reports to the board with respect to the performance
30 of health services contractors serving recipients of medical assistance, in-

1 cluding reports of trends in health services and enrollee satisfaction;

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

5 “(i) Be the state Medicaid agency for the administration of funds from
6 Titles XIX and XXI of the Social Security Act and administer medical as-
7 sistance under ORS chapter 414;

8 “(j) In consultation with the Director of the Department of Consumer and
9 Business Services, periodically review and recommend standards and meth-
10 odologies to the Legislative Assembly for:

11 “(A) Review of administrative expenses of health insurers;

12 “(B) Approval of rates; and

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

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

21 “(L) Guide and support community three-share agreements in which an
22 employer, state or local government and an individual all contribute a por-
23 tion of a premium for a community-centered health initiative or for insur-
24 ance coverage;

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

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

30 “(o) Implement a process for collecting the health outcome and quality

1 measure data identified by the Health [*Plan*] Quality Metrics Committee and
2 report the data to the Oregon Health Policy Board.

3 “(2) The Oregon Health Authority is authorized to:

4 “(a) Create an all-claims, all-payer database to collect health care data
5 and monitor and evaluate health care reform in Oregon and to provide
6 comparative cost and quality information to consumers, providers and pur-
7 chasers of health care about Oregon’s health care systems and health plan
8 networks in order to provide comparative information to consumers.

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

11 “(A) Uniform quality standards and performance measures;

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

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

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

18 “(3) The enumeration of duties, functions and powers in this section is
19 not intended to be exclusive nor to limit the duties, functions and powers
20 imposed on or vested in the Oregon Health Authority by ORS 413.006 to
21 413.042 and 741.340 or by other statutes.

22 “**SECTION 10.** ORS 414.025 is amended to read:

23 “414.025. As used in this chapter and ORS chapters 411 and 413, unless
24 the context or a specially applicable statutory definition requires otherwise:

25 “(1)(a) ‘Alternative payment methodology’ means a payment other than a
26 fee-for-services payment, used by coordinated care organizations as compen-
27 sation for the provision of integrated and coordinated health care and ser-
28 vices.

29 “(b) ‘Alternative payment methodology’ includes, but is not limited to:

30 “(A) Shared savings arrangements;

1 “(B) Bundled payments; and

2 “(C) Payments based on episodes.

3 “(2) ‘Behavioral health assessment’ means an evaluation by a behavioral
4 health clinician, in person or using telemedicine, to determine a patient’s
5 need for immediate crisis stabilization.

6 “(3) ‘Behavioral health clinician’ means:

7 “(a) A licensed psychiatrist;

8 “(b) A licensed psychologist;

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

11 “(d) A licensed clinical social worker;

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

14 “(f) A certified clinical social work associate;

15 “(g) An intern or resident who is working under a board-approved super-
16 visory contract in a clinical mental health field; or

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

19 “(4) ‘Behavioral health crisis’ means a disruption in an individual’s men-
20 tal or emotional stability or functioning resulting in an urgent need for im-
21 mediate outpatient treatment in an emergency department or admission to
22 a hospital to prevent a serious deterioration in the individual’s mental or
23 physical health.

24 “(5) ‘Behavioral health home’ means a mental health disorder or sub-
25 stance use disorder treatment organization, as defined by the Oregon Health
26 Authority by rule, that provides integrated health care to individuals whose
27 primary diagnoses are mental health disorders or substance use disorders.

28 “(6) ‘Category of aid’ means assistance provided by the Oregon Supple-
29 mental Income Program, aid granted under ORS 411.877 to 411.896 and
30 412.001 to 412.069 or federal Supplemental Security Income payments.

1 “(7) ‘Community health worker’ means an individual who meets quali-
2 fication criteria adopted by the authority under ORS 414.665 and who:

3 “(a) Has expertise or experience in public health;

4 “(b) Works in an urban or rural community, either for pay or as a vol-
5 unteer in association with a local health care system;

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

9 “(d) Assists members of the community to improve their health and in-
10 creases the capacity of the community to meet the health care needs of its
11 residents and achieve wellness;

12 “(e) Provides health education and information that is culturally appro-
13 priate to the individuals being served;

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

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

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

18 “(8) ‘Coordinated care organization’ means an organization meeting cri-
19 teria adopted by the Oregon Health Authority under ORS 414.625.

20 “(9) ‘Dually eligible for Medicare and Medicaid’ means, with respect to
21 eligibility for enrollment in a coordinated care organization, that an indi-
22 vidual is eligible for health services funded by Title XIX of the Social Se-
23 curity Act and is:

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

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

27 “(10)(a) ‘Family support specialist’ means an individual who meets quali-
28 fication criteria adopted by the authority under ORS 414.665 and who pro-
29 vides supportive services to and has experience parenting a child who:

30 “(A) Is a current or former consumer of mental health or addiction

1 treatment; or

2 “(B) Is facing or has faced difficulties in accessing education, health and
3 wellness services due to a mental health or behavioral health barrier.

4 “(b) A ‘family support specialist’ may be a peer wellness specialist or a
5 peer support specialist.

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

10 “(12) ‘Health insurance exchange’ or ‘exchange’ means an American
11 Health Benefit Exchange described in 42 U.S.C. 18031, 18032, 18033 and 18041.

12 “(13) ‘Health services’ means at least so much of each of the following
13 as are funded by the Legislative Assembly based upon the prioritized list of
14 health services compiled by the Health Evidence Review Commission under
15 ORS 414.690:

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

18 “(b) Services provided by a physician as defined in ORS 677.010, a nurse
19 practitioner certified under ORS 678.375, a behavioral health clinician or
20 other licensed practitioner within the scope of the practitioner’s practice as
21 defined by state law, and ambulance services;

22 “(c) Prescription drugs;

23 “(d) Laboratory and X-ray services;

24 “(e) Medical equipment and supplies;

25 “(f) Mental health services;

26 “(g) Chemical dependency services;

27 “(h) Emergency dental services;

28 “(i) Nonemergency dental services;

29 “(j) Provider services, other than services described in paragraphs (a) to
30 (i), (k), (L) and (m) of this subsection, defined by federal law that may be

1 included in the state’s medical assistance program;

2 “(k) Emergency hospital services;

3 “(L) Outpatient hospital services; and

4 “(m) Inpatient hospital services.

5 “(14) ‘Income’ has the meaning given that term in ORS 411.704.

6 “(15)(a) ‘Integrated health care’ means care provided to individuals and
7 their families in a patient centered primary care home or behavioral health
8 home by licensed primary care clinicians, behavioral health clinicians and
9 other care team members, working together to address one or more of the
10 following:

11 “(A) Mental illness.

12 “(B) Substance use disorders.

13 “(C) Health behaviors that contribute to chronic illness.

14 “(D) Life stressors and crises.

15 “(E) Developmental risks and conditions.

16 “(F) Stress-related physical symptoms.

17 “(G) Preventive care.

18 “(H) Ineffective patterns of health care utilization.

19 “(b) As used in this subsection, ‘other care team members’ includes but
20 is not limited to:

21 “(A) Qualified mental health professionals or qualified mental health as-
22 sociates meeting requirements adopted by the Oregon Health Authority by
23 rule;

24 “(B) Peer wellness specialists;

25 “(C) Peer support specialists;

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

28 “(E) Personal health navigators; or

29 “(F) Other qualified individuals approved by the Oregon Health Author-
30 ity.

1 “(16) ‘Investments and savings’ means cash, securities as defined in ORS
2 59.015, negotiable instruments as defined in ORS 73.0104 and such similar
3 investments or savings as the department or the authority may establish by
4 rule that are available to the applicant or recipient to contribute toward
5 meeting the needs of the applicant or recipient.

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

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

19 “(19) ‘Patient centered primary care home’ means a health care team or
20 clinic that is organized in accordance with the standards established by the
21 Oregon Health Authority under ORS 414.655 and that incorporates the fol-
22 lowing core attributes:

23 “(a) Access to care;

24 “(b) Accountability to consumers and to the community;

25 “(c) Comprehensive whole person care;

26 “(d) Continuity of care;

27 “(e) Coordination and integration of care; and

28 “(f) Person and family centered care.

29 “(20) ‘Peer support specialist’ means any of the following individuals who
30 meet qualification criteria adopted by the authority under ORS 414.665 and

1 who provide supportive services to a current or former consumer of mental
2 health or addiction treatment:

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

5 “(b) An individual who is in recovery, as defined by the Oregon Health
6 Authority by rule, from an addiction disorder.

7 “(21) ‘Peer wellness specialist’ means an individual who meets qualifica-
8 tion criteria adopted by the authority under ORS 414.665 and who is re-
9 sponsible for assessing mental health and substance use disorder service and
10 support needs of a member of a coordinated care organization through com-
11 munity outreach, assisting members with access to available services and
12 resources, addressing barriers to services and providing education and in-
13 formation about available resources for individuals with mental health or
14 substance use disorders in order to reduce stigma and discrimination toward
15 consumers of mental health and substance use disorder services and to assist
16 the member in creating and maintaining recovery, health and wellness.

17 “(22) ‘Person centered care’ means care that:

18 “(a) Reflects the individual patient’s strengths and preferences;

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

21 “(c) Is based upon the patient’s goals and will assist the patient in
22 achieving the goals.

23 “(23) ‘Personal health navigator’ means an individual who meets quali-
24 fication criteria adopted by the authority under ORS 414.665 and who pro-
25 vides information, assistance, tools and support to enable a patient to make
26 the best health care decisions in the patient’s particular circumstances and
27 in light of the patient’s needs, lifestyle, combination of conditions and de-
28 sired outcomes.

29 “(24) ‘Prepaid managed care health services organization’ means a man-
30 aged dental care, mental health or chemical dependency organization that

1 contracts with the authority under ORS 414.654 or with a coordinated care
2 organization on a prepaid capitated basis to provide health services to med-
3 ical assistance recipients.

4 “(25) ‘Quality measure’ means the [*health outcome and quality measures*]
5 **measures of health outcomes and health care quality** and benchmarks
6 identified by the Health [*Plan*] Quality Metrics Committee and the metrics
7 and scoring subcommittee in accordance with ORS 413.017 (4) and 414.638.

8 “(26) ‘Resources’ has the meaning given that term in ORS 411.704. For
9 eligibility purposes, ‘resources’ does not include charitable contributions
10 raised by a community to assist with medical expenses.

11 “(27)(a) ‘Youth support specialist’ means an individual who meets quali-
12 fication criteria adopted by the authority under ORS 414.665 and who, based
13 on a similar life experience, provides supportive services to an individual
14 who:

15 “(A) Is not older than 30 years of age; and

16 “(B)(i) Is a current or former consumer of mental health or addiction
17 treatment; or

18 “(ii) Is facing or has faced difficulties in accessing education, health and
19 wellness services due to a mental health or behavioral health barrier.

20 “(b) A ‘youth support specialist’ may be a peer wellness specialist or a
21 peer support specialist.

22 “**SECTION 11.** ORS 414.065 is amended to read:

23 “414.065. (1)(a) With respect to health care and services to be provided in
24 medical assistance during any period, the Oregon Health Authority shall
25 determine, subject to such revisions as it may make from time to time and
26 subject to legislative funding and paragraph (b) of this subsection:

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

29 “(B) Standards, including [*outcome and quality measures*] **measures of**
30 **health outcomes and health care quality**, to be observed in the provision

1 of health care and services.

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

4 “(D) Reasonable fees, charges, daily rates and global payments for meet-
5 ing the costs of providing health services to an applicant or recipient.

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

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

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

13 “(2) The types and extent of health care and services and the amounts to
14 be paid in meeting the costs thereof, as determined and fixed by the author-
15 ity and within the limits of funds available therefor, shall be the total
16 available for medical assistance and payments for such medical assistance
17 shall be the total amounts from medical assistance funds available to pro-
18 viders of health care and services in meeting the costs thereof.

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

23 “(4) Notwithstanding subsections (1) and (2) of this section, the Depart-
24 ment of Human Services shall be responsible for determining the payment for
25 Medicaid-funded long term care services and for contracting with the pro-
26 viders of long term care services.

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

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

30 “(b) The authority shall consider the community health assessment con-

1 ducted by the organization and reviewed annually, and the organization's
2 health care costs; and

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

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

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

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

13 **“SECTION 12.** ORS 414.625, as amended by section 3, chapter 49, Oregon
14 Laws 2018, is amended to read:

15 “414.625. (1) The Oregon Health Authority shall adopt by rule the quali-
16 fication criteria and requirements for a coordinated care organization and
17 shall integrate the criteria and requirements into each contract with a co-
18 ordinated care organization. Coordinated care organizations may be local,
19 community-based organizations or statewide organizations with community-
20 based participation in governance or any combination of the two. Coordi-
21 nated care organizations may contract with counties or with other public or
22 private entities to provide services to members. The authority may not con-
23 tract with only one statewide organization. A coordinated care organization
24 may be a single corporate structure or a network of providers organized
25 through contractual relationships. The criteria and requirements adopted by
26 the authority under this section must include, but are not limited to, a re-
27 quirement that the coordinated care organization:

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

30 “(b) Meet the following minimum financial requirements:

1 “(A) Maintain restricted reserves of \$250,000 plus an amount equal to 50
2 percent of the coordinated care organization’s total actual or projected li-
3 abilities above \$250,000.

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

7 “(C) Expend a portion of the annual net income or reserves of the coor-
8 dinated care organization that exceed the financial requirements specified in
9 this paragraph on services designed to address health disparities and the
10 social determinants of health consistent with the coordinated care
11 organization’s community health improvement plan and transformation plan
12 and the terms and conditions of the Medicaid demonstration project under
13 section 1115 of the Social Security Act (42 U.S.C. 1315).

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

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

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

24 “(f) Engage community members and health care providers in improving
25 the health of the community and addressing regional, cultural, socioeconomic
26 and racial disparities in health care that exist among the coordinated care
27 organization’s members and in the coordinated care organization’s commu-
28 nity.

29 “(2) In addition to the criteria and requirements specified in subsection
30 (1) of this section, the authority must adopt by rule requirements for coor-

1 dinated care organizations contracting with the authority so that:

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

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

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

12 “(d) Members receive comprehensive transitional care, including appro-
13 priate follow-up, when entering and leaving an acute care facility or a long
14 term care setting.

15 “(e) Members receive assistance in navigating the health care delivery
16 system and in accessing community and social support services and statewide
17 resources, including through the use of certified health care interpreters and
18 qualified health care interpreters, as those terms are defined in ORS 413.550.

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

23 “(g) Each coordinated care organization uses health information technol-
24 ogy to link services and care providers across the continuum of care to the
25 greatest extent practicable and if financially viable.

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

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

30 “(j) Each coordinated care organization prioritizes working with members

1 who have high health care needs, multiple chronic conditions, mental illness
2 or chemical dependency and involves those members in accessing and man-
3 aging appropriate preventive, health, remedial and supportive care and ser-
4 vices, including the services described in ORS 414.766, to reduce the use of
5 avoidable emergency room visits and hospital admissions.

6 “(k) Members have a choice of providers within the coordinated care
7 organization’s network and that providers participating in a coordinated care
8 organization:

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

11 “(B) Are educated about the integrated approach and how to access and
12 communicate within the integrated system about a patient’s treatment plan
13 and health history.

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

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

18 “(E) Include providers of specialty care.

19 “(F) Are selected by coordinated care organizations using universal ap-
20 plication and credentialing procedures and objective quality information and
21 are removed if the providers fail to meet objective quality standards.

22 “(G) Work together to develop best practices for culturally appropriate
23 care and service delivery to reduce waste, reduce health disparities and im-
24 prove the health and well-being of members.

25 “(L) Each coordinated care organization reports on [*outcome and quality*
26 *measures*] **measures of health outcomes and health care quality** adopted
27 under ORS 414.638 and participates in the health care data reporting system
28 established in ORS 442.464 and 442.466.

29 “(m) Each coordinated care organization uses best practices in the man-
30 agement of finances, contracts, claims processing, payment functions and

1 provider networks.

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

4 “(o) Each coordinated care organization has a governing body that com-
5 plies with section 2, chapter 49, Oregon Laws 2018, and that includes:

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

8 “(B) A representative of a dental care organization selected by the coor-
9 dinated care organization;

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

11 “(D) At least two health care providers in active practice, including:

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

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

15 “(E) At least two members from the community at large, to ensure that
16 the organization’s decision-making is consistent with the values of the
17 members and the community; and

18 “(F) At least one member of the community advisory council.

19 “(p) Each coordinated care organization’s governing body establishes
20 standards for publicizing the activities of the coordinated care organization
21 and the organization’s community advisory councils, as necessary, to keep
22 the community informed.

23 “(3) The authority shall consider the participation of area agencies and
24 other nonprofit agencies in the configuration of coordinated care organiza-
25 tions.

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

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

30 “(b) For providers, optimize choice in contracting with coordinated care

1 organizations; and

2 “(c) Allow more than one coordinated care organization to serve the ge-
3 ographic area if necessary to optimize access and choice under this sub-
4 section.

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

9 **“SECTION 13.** ORS 414.625, as amended by section 14, chapter 489,
10 Oregon Laws 2017, and section 4, chapter 49, Oregon Laws 2018, is amended
11 to read:

12 “414.625. (1) The Oregon Health Authority shall adopt by rule the quali-
13 fication criteria and requirements for a coordinated care organization and
14 shall integrate the criteria and requirements into each contract with a co-
15 ordinated care organization. Coordinated care organizations may be local,
16 community-based organizations or statewide organizations with community-
17 based participation in governance or any combination of the two. Coordi-
18 nated care organizations may contract with counties or with other public or
19 private entities to provide services to members. The authority may not con-
20 tract with only one statewide organization. A coordinated care organization
21 may be a single corporate structure or a network of providers organized
22 through contractual relationships. The criteria and requirements adopted by
23 the authority under this section must include, but are not limited to, a re-
24 quirement that the coordinated care organization:

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

27 “(b) Meet the following minimum financial requirements:

28 “(A) Maintain restricted reserves of \$250,000 plus an amount equal to 50
29 percent of the coordinated care organization’s total actual or projected li-
30 abilities above \$250,000.

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

4 “(C) Expend a portion of the annual net income or reserves of the coor-
5 dinated care organization that exceed the financial requirements specified in
6 this paragraph on services designed to address health disparities and the
7 social determinants of health consistent with the coordinated care
8 organization’s community health improvement plan and transformation plan
9 and the terms and conditions of the Medicaid demonstration project under
10 section 1115 of the Social Security Act (42 U.S.C. 1315).

11 “(c) Operate within a fixed global budget and spend on primary care, as
12 defined by the authority by rule, at least 12 percent of the coordinated care
13 organization’s total expenditures for physical and mental health care pro-
14 vided to members, except for expenditures on prescription drugs, vision care
15 and dental care.

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

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

21 “(f) Engage community members and health care providers in improving
22 the health of the community and addressing regional, cultural, socioeconomic
23 and racial disparities in health care that exist among the coordinated care
24 organization’s members and in the coordinated care organization’s commu-
25 nity.

26 “(2) In addition to the criteria and requirements specified in subsection
27 (1) of this section, the authority must adopt by rule requirements for coor-
28 dinated care organizations contracting with the authority so that:

29 “(a) Each member of the coordinated care organization receives integrated
30 person centered care and services designed to provide choice, independence

1 and dignity.

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

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

9 “(d) Members receive comprehensive transitional care, including appro-
10 priate follow-up, when entering and leaving an acute care facility or a long
11 term care setting.

12 “(e) Members receive assistance in navigating the health care delivery
13 system and in accessing community and social support services and statewide
14 resources, including through the use of certified health care interpreters and
15 qualified health care interpreters, as those terms are defined in ORS 413.550.

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

20 “(g) Each coordinated care organization uses health information technol-
21 ogy to link services and care providers across the continuum of care to the
22 greatest extent practicable and if financially viable.

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

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

27 “(j) Each coordinated care organization prioritizes working with members
28 who have high health care needs, multiple chronic conditions, mental illness
29 or chemical dependency and involves those members in accessing and man-
30 aging appropriate preventive, health, remedial and supportive care and ser-

1 vices, including the services described in ORS 414.766, to reduce the use of
2 avoidable emergency room visits and hospital admissions.

3 “(k) Members have a choice of providers within the coordinated care
4 organization’s network and that providers participating in a coordinated care
5 organization:

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

8 “(B) Are educated about the integrated approach and how to access and
9 communicate within the integrated system about a patient’s treatment plan
10 and health history.

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

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

15 “(E) Include providers of specialty care.

16 “(F) Are selected by coordinated care organizations using universal ap-
17 plication and credentialing procedures and objective quality information and
18 are removed if the providers fail to meet objective quality standards.

19 “(G) Work together to develop best practices for culturally appropriate
20 care and service delivery to reduce waste, reduce health disparities and im-
21 prove the health and well-being of members.

22 “(L) Each coordinated care organization reports on [*outcome and quality*
23 *measures*] **measures of health outcomes and health care quality** adopted
24 under ORS 414.638 and participates in the health care data reporting system
25 established in ORS 442.464 and 442.466.

26 “(m) Each coordinated care organization uses best practices in the man-
27 agement of finances, contracts, claims processing, payment functions and
28 provider networks.

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

1 “(o) Each coordinated care organization has a governing body that com-
2 plies with section 2, chapter 49, Oregon Laws 2018, and that includes:

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

5 “(B) A representative of a dental care organization selected by the coor-
6 dinated care organization;

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

8 “(D) At least two health care providers in active practice, including:

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

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

12 “(E) At least two members from the community at large, to ensure that
13 the organization’s decision-making is consistent with the values of the
14 members and the community; and

15 “(F) At least one member of the community advisory council.

16 “(p) Each coordinated care organization’s governing body establishes
17 standards for publicizing the activities of the coordinated care organization
18 and the organization’s community advisory councils, as necessary, to keep
19 the community informed.

20 “(3) The authority shall consider the participation of area agencies and
21 other nonprofit agencies in the configuration of coordinated care organiza-
22 tions.

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

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

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

29 “(c) Allow more than one coordinated care organization to serve the ge-
30 ographic area if necessary to optimize access and choice under this sub-

1 section.

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

6 “**SECTION 14.** ORS 414.638 is amended to read:

7 “414.638. (1) There is created in the Health [*Plan*] Quality Metrics Com-
8 mittee a nine-member metrics and scoring subcommittee appointed by the
9 Director of the Oregon Health Authority. The members of the subcommittee
10 serve two-year terms and must include:

11 “(a) Three members at large;

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

13 “(c) Three representatives of coordinated care organizations.

14 “(2) The subcommittee shall select, from the [*health outcome and quality*
15 *measures*] **measures of health outcomes and health care quality** identi-
16 fied by the Health [*Plan*] Quality Metrics Committee, the [*health outcome*
17 *and quality measures*] **measures of health outcomes and health care**
18 **quality** applicable to services provided by coordinated care organizations.
19 The Oregon Health Authority shall incorporate these measures into coordi-
20 nated care organization contracts to hold the organizations accountable for
21 performance and customer satisfaction requirements. The authority shall
22 notify each coordinated care organization of any changes in the measures
23 at least three months before the beginning of the contract period during
24 which the new measures will be in place.

25 “(3) The subcommittee shall evaluate the [*health outcome and quality*
26 *measures*] **measures of health outcomes and health care quality** annu-
27 ally, reporting recommendations based on its findings to the Health [*Plan*]
28 Quality Metrics Committee, and adjust the measures to reflect:

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

30 “(b) Changes in membership of the organization;

1 “(c) The organization’s costs for implementing [*outcome and quality*
2 *measures*] **measures of health outcomes and health care quality**; and

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

5 “(4) The authority shall evaluate on a regular and ongoing basis the
6 [*outcome and quality measures*] **measures of health outcomes and health**
7 **care quality** selected by the subcommittee under this section for members
8 in each coordinated care organization and for members statewide.

9 **“SECTION 15.** ORS 414.652, as amended by section 5, chapter 49, Oregon
10 Laws 2018, is amended to read:

11 “414.652. (1) As used in this section:

12 “(a) ‘Benefit period’ means a period of time, shorter than the five-year
13 contract term, for which specific terms and conditions in a contract between
14 a coordinated care organization and the Oregon Health Authority are in ef-
15 fect.

16 “(b) ‘Renew’ means an agreement by a coordinated care organization to
17 amend the terms or conditions of an existing contract for the next benefit
18 period.

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

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

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

24 “(c) May be terminated by the authority if a coordinated care organiza-
25 tion fails to meet [*outcome and quality measures*] **measures of health out-**
26 **comes and health care quality** specified in the contract or is otherwise in
27 breach of the contract.

28 “(3) This section does not prohibit the authority from allowing a coordi-
29 nated care organization a reasonable amount of time in which to cure any
30 failure to meet [*outcome and quality measures*] **measures of health out-**

1 **comes and health care quality** specified in the contract prior to the ter-
2 mination of the contract.

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

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

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

8 “(5) Except as provided in subsection (7) of this section, the authority
9 must give a coordinated care organization at least 60 days’ advance notice
10 of any amendments the authority proposes to existing contracts between the
11 authority and the coordinated care organization.

12 “(6) An amendment to a contract may apply retroactively only if:

13 “(a) The amendment does not result in a claim by the authority for the
14 recovery of amounts paid by the authority to the coordinated care organiza-
15 tion prior to the date of the amendment; or

16 “(b) The Centers for Medicare and Medicaid Services notifies the au-
17 thority, in writing, that the amendment is a condition for approval of the
18 contract by the Centers for Medicare and Medicaid Services.

19 “(7) No later than 134 days prior to the end of a benefit period, the au-
20 thority shall provide to each coordinated care organization notice of the
21 proposed changes to the terms and conditions of a contract, as will be sub-
22 mitted to the Centers for Medicare and Medicaid Services for approval, for
23 the next benefit period.

24 “(8) A coordinated care organization must notify the authority of the co-
25 ordinated care organization’s refusal to renew a contract with the authority
26 no later than 14 days after the authority provides the notice described in
27 subsection (7) of this section. Except as provided in subsections (9) and (10)
28 of this section, a refusal to renew terminates the contract at the end of the
29 benefit period.

30 “(9) The authority may require a contract to remain in force into the next

1 benefit period and be amended as proposed by the authority until 90 days
2 after the coordinated care organization has, in accordance with criteria
3 prescribed by the authority:

4 “(a) Notified each of its members and contracted providers of the termi-
5 nation of the contract;

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

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

10 “(10) The authority may waive compliance with the deadlines in sub-
11 sections (8) and (9) of this section if the Director of the Oregon Health Au-
12 thority finds that the waiver of the deadlines is consistent with the effective
13 and efficient administration of the medical assistance program and the pro-
14 tection of medical assistance recipients.

15 **“SECTION 16.** ORS 414.652, as amended by section 5, chapter 49, Oregon
16 Laws 2018, is amended to read:

17 “414.652. (1) As used in this section:

18 “(a) ‘Benefit period’ means a period of time, shorter than the five-year
19 contract term, for which specific terms and conditions in a contract between
20 a coordinated care organization and the Oregon Health Authority are in ef-
21 fect.

22 “(b) ‘Renew’ means an agreement by a coordinated care organization to
23 amend the terms or conditions of an existing contract for the next benefit
24 period.

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

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

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

30 “(c) May be terminated by the authority if a coordinated care organiza-

1 tion fails to meet [*outcome and quality measures*] **measures of health out-**
2 **comes and health care quality** specified in the contract or is otherwise in
3 breach of the contract.

4 “(3) This section does not prohibit the authority from allowing a coordi-
5 nated care organization a reasonable amount of time in which to cure any
6 failure to meet [*outcome and quality measures*] **measures of health out-**
7 **comes and health care quality** specified in the contract prior to the ter-
8 mination of the contract.

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

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

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

14 “(5) Except as provided in subsection (7) of this section, the authority
15 must give a coordinated care organization at least 60 days’ advance notice
16 of any amendments the authority proposes to existing contracts between the
17 authority and the coordinated care organization.

18 “(6) An amendment to a contract may apply retroactively only if:

19 “(a) The amendment does not result in a claim by the authority for the
20 recovery of amounts paid by the authority to the coordinated care organiza-
21 tion prior to the date of the amendment; or

22 “(b) The Centers for Medicare and Medicaid Services notifies the au-
23 thority, in writing, that the amendment is a condition for approval of the
24 contract by the Centers for Medicare and Medicaid Services.

25 “(7) No later than 134 days prior to the end of a benefit period, the au-
26 thority shall provide to each coordinated care organization notice of the
27 proposed changes to the terms and conditions of a contract, as will be sub-
28 mitted to the Centers for Medicare and Medicaid Services for approval, for
29 the next benefit period.

30 “(8) A coordinated care organization must notify the authority of the co-

1 ordained care organization’s refusal to renew a contract with the authority
2 no later than 14 days after the authority provides the notice described in
3 subsection (7) of this section. Except as provided in subsections (9) and (10)
4 of this section, a refusal to renew terminates the contract at the end of the
5 benefit period.

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

10 “(a) Notified each of its members and contracted providers of the termi-
11 nation of the contract;

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

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

16 “(10) The authority may waive compliance with the deadlines in sub-
17 sections (8) and (9) of this section if the Director of the Oregon Health Au-
18 thority finds that the waiver of the deadlines is consistent with the effective
19 and efficient administration of the medical assistance program and the pro-
20 tection of medical assistance recipients.

21 **“SECTION 17.** ORS 417.721 is amended to read:

22 “417.721. The Oregon Health Authority, the Health [*Plan*] Quality Metrics
23 Committee and the Early Learning Council shall work collaboratively with
24 coordinated care organizations to develop performance metrics for prenatal
25 care, delivery and infant care that align with early learning outcomes.

26 **“SECTION 18.** Section 1, chapter 389, Oregon Laws 2015, is amended to
27 read:

28 **“Sec. 1.** (1) The Oregon Health Policy Board, in consultation with the
29 Public Employees’ Benefit Board, the Oregon Educators Benefit Board, the
30 Oregon Health Authority and the Department of Consumer and Business

1 Services shall develop a statewide strategic plan for the collection and use
2 of health care data. The plan must:

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

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

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

11 “(d) Include strategies to ensure that the state’s collection, use and
12 measurement of health care data advance payment reform and allow for al-
13 ternative payment methodologies;

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

17 “(f) Identify appropriate and inappropriate uses of health care data, in-
18 cluding safeguards to ensure privacy and ensure that data is not used for
19 marketing or other inappropriate purposes; and

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

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

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

29 **“SECTION 19.** Section 3, chapter 389, Oregon Laws 2015, is amended to
30 read:

1 “**Sec. 3.** The Oregon Health Authority shall submit two reports to the
2 Legislative Assembly, in the manner provided in ORS 192.245, on the activ-
3 ities of the Health [*Plan*] Quality Metrics Committee and the authority in
4 complying with the provisions of ORS 413.017 (4)(b) to (f). The first report
5 shall be submitted during the 2017 regular session of the Legislative Assem-
6 bly. A second report shall be submitted during the 2019 regular session of
7 the Legislative Assembly.

8 “**SECTION 20.** Section 2, chapter 575, Oregon Laws 2015, as amended by
9 section 1, chapter 384, Oregon Laws 2017, and section 13, chapter 489, Oregon
10 Laws 2017, is amended to read:

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

12 “(a) ‘Carrier’ means an insurer that offers a health benefit plan, as de-
13 fined in ORS 743B.005.

14 “(b) ‘Coordinated care organization’ has the meaning given that term in
15 ORS 414.025.

16 “(c) ‘Primary care’ means family medicine, general internal medicine,
17 naturopathic medicine, obstetrics and gynecology, pediatrics or general psy-
18 chiatry.

19 “(d) ‘Primary care provider’ includes:

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

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

25 “(2)(a) The Oregon Health Authority shall convene a primary care pay-
26 ment reform collaborative to advise and assist in the implementation of a
27 Primary Care Transformation Initiative to:

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

30 “(i) Increase the investment in primary care;

1 “(ii) Align primary care reimbursement by all purchasers of care; and
2 “(iii) Continue to improve reimbursement methods, including by investing
3 in the social determinants of health;
4 “(B) Increase investment in primary care without increasing costs to
5 consumers or increasing the total cost of health care;
6 “(C) Provide technical assistance to clinics and payers in implementing
7 the initiative;
8 “(D) Aggregate the data from and align the metrics used in the initiative
9 with the work of the Health [*Plan*] Quality Metrics Committee established
10 in ORS 413.017;
11 “(E) Facilitate the integration of primary care behavioral and physical
12 health care; and
13 “(F) Ensure that the goals of the initiative are met by December 31, 2027.
14 “(b) The collaborative is a governing body, as defined in ORS 192.610.
15 “(3) The authority shall invite representatives from all of the following
16 to participate in the primary care payment reform collaborative:
17 “(a) Primary care providers;
18 “(b) Health care consumers;
19 “(c) Experts in primary care contracting and reimbursement;
20 “(d) Independent practice associations;
21 “(e) Behavioral health treatment providers;
22 “(f) Third party administrators;
23 “(g) Employers that offer self-insured health benefit plans;
24 “(h) The Department of Consumer and Business Services;
25 “(i) Carriers;
26 “(j) A statewide organization for mental health professionals who provide
27 primary care;
28 “(k) A statewide organization representing federally qualified health cen-
29 ters;
30 “(L) A statewide organization representing hospitals and health systems;

1 “(m) A statewide professional association for family physicians;

2 “(n) A statewide professional association for physicians;

3 “(o) A statewide professional association for nurses; and

4 “(p) The Centers for Medicare and Medicaid Services.

5 “(4) The primary care payment reform collaborative shall annually report
6 to the Oregon Health Policy Board and to the Legislative Assembly on the
7 achievement of the primary care spending targets in ORS 414.625 and 743.010
8 and the implementation of the Primary Care Transformation Initiative.

9 “(5) A coordinated care organization shall report to the authority, no
10 later than October 1 of each year, the proportion of the organization’s total
11 medical costs that are allocated to primary care.

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

15
