

SB 765-2  
(LC 2852)  
4/3/19 (LHF/ps)

Requested by Senator STEINER HAYWARD

**PROPOSED AMENDMENTS TO  
SENATE BILL 765**

1 On page 1 of the printed bill, line 2, after “243.105,” insert “243.107,” and  
2 after “243.866,” insert “279A.025.”

3 In line 3, delete “, 743.010 and 743.020” and insert “and 743.010” and after  
4 “2” insert “, 3”.

5 Delete lines 7 through 27 and delete pages 2 through 20.

6 On page 21, delete lines 1 through 35 and insert:

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

8 **“(a) ‘Behavioral health clinician’ means:**

9 **“(A) A psychiatrist;**

10 **“(B) A psychologist licensed under ORS 675.010 to 675.150;**

11 **“(C) A nurse practitioner, licensed under ORS 678.375 to 678.390,**  
12 **with a specialty in psychiatric mental health;**

13 **“(D) A clinical social worker licensed under ORS 675.530;**

14 **“(E) A marriage and family therapist or professional counselor li-**  
15 **censed under ORS 675.715;**

16 **“(F) A clinical social work associate certified under ORS 675.537; or**

17 **“(G) An intern or resident who is working under a board-approved**  
18 **supervisory contract in a clinical mental health field.**

19 **“(b) ‘Primary care’ means family medicine, general internal medi-**  
20 **cine, naturopathic medicine, pediatrics and care provided by primary**  
21 **care integrated behavioral health clinicians or primary care integrated**

1 **women’s health clinicians.**

2 **“(c) ‘Primary care integrated behavioral health clinician’ means:**

3 **“(A) A care team member as defined in ORS 414.025 (15)(b); or**

4 **“(B) A behavioral health clinician providing care to individuals and**  
5 **families in a patient centered primary care home to address one or**  
6 **more of the following:**

7 **“(i) Mental illness.**

8 **“(ii) Substance use disorders.**

9 **“(iii) Health behaviors that contribute to chronic illness.**

10 **“(iv) Life stressors and crises.**

11 **“(v) Developmental risks and conditions.**

12 **“(vi) Stress-related physical symptoms.**

13 **“(vii) Preventive care.**

14 **“(viii) Ineffective patterns of health care utilization.**

15 **“(d) ‘Primary care integrated women’s health clinician’ means one**  
16 **of the following clinicians whose practice is focused on women’s health**  
17 **and primary care and who provides a range of the services within a**  
18 **patient centered primary care home:**

19 **“(A) A physician who is an obstetrician or gynecologist;**

20 **“(B) A nurse practitioner;**

21 **“(C) A physician assistant; or**

22 **“(D) Another health professional licensed or certified in this state.**

23 **“(e) ‘Total medical expenditures’ means total expenditures for**  
24 **physical and mental health care provided to members of a coordinated**  
25 **care organization, excluding expenditures for vision care and dental**  
26 **care.**

27 **“(2) No later than January 1, 2023, a coordinated care organization**  
28 **must spend at least 12 percent of the coordinated care organization’s**  
29 **total medical expenditures on primary care.**

30 **“(3) No later than January 1, 2020, a coordinated care organization**

1 **must reimburse a percentage, as established by the Oregon Health**  
2 **Authority by rule, of all primary care costs using alternative payment**  
3 **methodologies.**

4 **“(4) After the Oregon Health Authority has established a global**  
5 **budget for a coordinated care organization for a calendar year, the**  
6 **coordinated care organization shall report to the authority, at the time**  
7 **and in the manner prescribed by the authority by rule:**

8 **“(a) The percentage of the global budget that the coordinated care**  
9 **organization anticipates spending on primary care in the calendar**  
10 **year;**

11 **“(b) The percentage of the spending on primary care that will be in**  
12 **the form of alternative payment methodologies in the calendar year;**  
13 **and**

14 **“(c) The types of alternative payment methodologies that the coor-**  
15 **ordinated care organization will use during the calendar year.**

16 **“SECTION 3.** ORS 243.105 is amended to read:

17 **“243.105. As used in ORS 243.105 to 243.285, unless the context requires**  
18 **otherwise:**

19 **“(1) ‘Behavioral health clinician’ means:**

20 **“(a) A psychiatrist;**

21 **“(b) A psychologist licensed under ORS 675.010 to 675.150;**

22 **“(c) A nurse practitioner, licensed under ORS 678.375 to 678.390, with**  
23 **a specialty in psychiatric mental health;**

24 **“(d) A clinical social worker licensed under ORS 675.530;**

25 **“(e) A marriage and family therapist or professional counselor li-**  
26 **censed under ORS 675.715;**

27 **“(f) A clinical social work associate certified under ORS 675.537; or**

28 **“(g) An intern or resident who is working under a board-approved**  
29 **supervisory contract in a clinical mental health field.**

30 **“[(1)] (2) ‘Benefit plan’ includes, but is not limited to:**

1       “(a) Contracts for insurance or other benefits, including medical, dental,  
2 vision, life, disability and other health care recognized by state law, and re-  
3 lated services and supplies;

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

6       “(c) Self-insurance programs managed by the Public Employees’ Benefit  
7 Board.

8       “[(2)] **(3)** ‘Board’ means the Public Employees’ Benefit Board.

9       “[(3)] **(4)** ‘Carrier’ means an insurance company or health care service  
10 contractor holding a valid certificate of authority from the Director of the  
11 Department of Consumer and Business Services, or two or more companies  
12 or contractors acting together pursuant to a joint venture, partnership or  
13 other joint means of operation, or a board-approved guarantor of benefit plan  
14 coverage and compensation.

15       “[(4)(a)] **(5)(a)** ‘Eligible employee’ means an officer or employee of a state  
16 agency or local government who elects to participate in one of the group  
17 benefit plans described in ORS 243.135. The term includes, but is not limited  
18 to, state officers and employees in the exempt, unclassified and classified  
19 service, and state officers and employees, whether or not retired, who:

20       “(A) Are receiving a service retirement allowance, a disability retirement  
21 allowance or a pension under the Public Employees Retirement System or  
22 are receiving a service retirement allowance, a disability retirement allow-  
23 ance or a pension under any other retirement or disability benefit plan or  
24 system offered by the State of Oregon for its officers and employees;

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

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

30       “(D) Are eligible to receive a service retirement allowance or pension

1 under another retirement benefit plan or system offered by the State of  
2 Oregon and have attained earliest retirement age under the plan or system.

3 “(b) ‘Eligible employee’ does not include individuals:

4 “(A) Engaged as independent contractors;

5 “(B) Whose periods of employment in emergency work are on an inter-  
6 mittent or irregular basis;

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

10 “(D) Appointed under ORS 240.309;

11 “(E) Provided sheltered employment or make-work by the state in an em-  
12 ployment or industries program maintained for the benefit of such individ-  
13 uals;

14 “(F) Provided student health care services in conjunction with their en-  
15 rollment as students at a public university listed in ORS 352.002; or

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

18 “[5] (6) ‘Family member’ means an eligible employee’s spouse and any  
19 unmarried child or stepchild within age limits and other conditions imposed  
20 by the board with regard to unmarried children or stepchildren.

21 “[6] (7) ‘Local government’ means any city, county or special district in  
22 this state or any intergovernmental entity created under ORS chapter 190.

23 “(8) **‘Patient centered primary care home’ has the meaning given**  
24 **that term in ORS 414.025.**

25 “[7] (9) ‘Payroll disbursing officer’ means the officer or official author-  
26 ized to disburse moneys in payment of salaries and wages of employees of a  
27 state agency or local government.

28 “[8] (10) ‘Premium’ means the monthly or other periodic charge for a  
29 benefit plan.

30 “[9] (11) ‘Primary care’ means family medicine, general internal medi-

1 cine, naturopathic medicine, [*obstetrics and gynecology*,] pediatrics [*or general*  
2 *psychiatry*.] **and care provided by primary care integrated behavioral**  
3 **health clinicians or primary care integrated women’s health clinicians.**

4 **“(12) ‘Primary care integrated behavioral health clinician’ means:**

5 **“(a) A care team member as defined in ORS 414.025 (15)(b); or**

6 **“(b) A behavioral health clinician providing care to individuals and**  
7 **families in a patient centered primary care home to address one or**  
8 **more of the following:**

9 **“(A) Mental illness.**

10 **“(B) Substance use disorders.**

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

12 **“(D) Life stressors and crises.**

13 **“(E) Developmental risks and conditions.**

14 **“(F) Stress-related physical symptoms.**

15 **“(G) Preventive care.**

16 **“(H) Ineffective patterns of health care utilization.**

17 **“(13) ‘Primary care integrated women’s health clinician’ means one**  
18 **of the following clinicians whose practice is focused on women’s health**  
19 **and primary care and who provides a range of the services within a**  
20 **patient centered primary care home:**

21 **“(a) A physician who is an obstetrician or gynecologist;**

22 **“(b) A nurse practitioner;**

23 **“(c) A physician assistant; or**

24 **“(d) Another health professional licensed or certified in this state.**

25 **“[(10)] (14) ‘State agency’ means every state officer, board, commission,**  
26 **department or other activity of state government.**

27 **“[(11)] (15) ‘Total medical expenditures’ means payments to reimburse the**  
28 **cost of physical and mental health care provided to eligible employees or**  
29 **their family members, excluding [*prescription drugs*,] vision care and dental**  
30 **care, whether paid on a fee-for-service basis or as part of a capitated rate**

1 or other type of payment mechanism.

2 **“SECTION 3a.** ORS 243.107 is amended to read:

3 “243.107. A person employed by a public university listed in ORS 352.002  
4 or the Oregon Health and Science University may be considered an eligible  
5 employee for participation in one of the group benefit plans described in ORS  
6 243.135 if the governing board of the public university, or the Oregon Health  
7 and Science University Board of Directors for Oregon Health and Science  
8 University employees, determines that funds are available therefor and if:

9 “(1) Notwithstanding ORS 243.105 [(4)(b)(F)] **(5)(b)(F)**, the person is a  
10 student enrolled in an institution of higher education and is employed as a  
11 graduate teaching assistant, graduate research assistant or a fellow at the  
12 institution and elects to participate; or

13 “(2) Notwithstanding ORS 243.105 [(4)(b)(B)] **(5)(b)(B)** or (C), the person  
14 is employed on a less than half-time basis in an unclassified instructional  
15 or research support capacity and elects to participate.”.

16 **“SECTION 4.** ORS 243.135 is amended to read:

17 “243.135. (1) Notwithstanding any other benefit plan contracted for and  
18 offered by the Public Employees’ Benefit Board, the board shall contract for  
19 a health benefit plan or plans best designed to meet the needs and provide  
20 for the welfare of eligible employees, the state and the local governments.  
21 In considering whether to enter into a contract for a plan, the board shall  
22 place emphasis on:

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

24 “(b) A competitive marketplace;

25 “(c) Plan performance and information;

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

27 “(e) Quality customer service;

28 “(f) Creativity and innovation;

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

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

1       “(i) Health outcome and quality measures, described in ORS 413.017 (4),  
2 that are reported by the plan.

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

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

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

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

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

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

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

1 for primary care.

2 **“(9) By January 1, 2020, the board shall reimburse a percentage, as**  
3 **established by rule by the Oregon Health Authority in collaboration**  
4 **with the Department of Consumer and Business Services, of all pri-**  
5 **mary care costs in self-insured health benefit plans offered to eligible**  
6 **employees using alternative payment methodologies, as defined in ORS**  
7 **414.025.**

8 **“(10) No later than December 1 of each calendar year, the board**  
9 **shall report to the authority, with respect to the self-insured health**  
10 **benefit plans offered to eligible employees for the next calendar year:**

11 **“(a) The percentage of total medical expenditures that the board**  
12 **anticipates spending on primary care;**

13 **“(b) The percentage of spending on primary care that will be in the**  
14 **form of alternative payment methodologies; and**

15 **“(c) The types of alternative payment methodologies that will be**  
16 **used to reimburse health care providers.**

17 **“[(9)] (11) No later than February 1 of each year, the board shall report**  
18 **to the Legislative Assembly on the board’s progress toward achieving the**  
19 **[target of spending at least 12 percent of total medical expenditures in self-**  
20 **insured health benefit plans on payments for primary care] **spending targets****  
21 **described in subsection (8) of this section and the board’s plan for**  
22 **achieving the targets.**

23 **“SECTION 5. ORS 243.135, as amended by section 27, chapter 746, Oregon**  
24 **Laws 2017, is amended to read:**

25 **“243.135. (1) Notwithstanding any other benefit plan contracted for and**  
26 **offered by the Public Employees’ Benefit Board, the board shall contract for**  
27 **a health benefit plan or plans best designed to meet the needs and provide**  
28 **for the welfare of eligible employees, the state and the local governments.**  
29 **In considering whether to enter into a contract for a plan, the board shall**  
30 **place emphasis on:**

1       “(a) Employee choice among high quality plans;  
2       “(b) A competitive marketplace;  
3       “(c) Plan performance and information;  
4       “(d) Employer flexibility in plan design and contracting;  
5       “(e) Quality customer service;  
6       “(f) Creativity and innovation;  
7       “(g) Plan benefits as part of total employee compensation;  
8       “(h) The improvement of employee health; and  
9       “(i) Health outcome and quality measures, described in ORS 413.017 (4),  
10 that are reported by the plan.

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

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

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

29       “(5) In developing any health benefit plan, the board may provide an op-  
30 tion of additional coverage for eligible employees and their family members

1 at an additional cost or premium.

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

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

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

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

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

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

29 **“(11) By January 1, 2020, the board shall reimburse a percentage,**  
30 **as established by rule by the Oregon Health Authority in collaboration**

1 with the Department of Consumer and Business Services, of all pri-  
2 mary care costs in self-insured health benefit plans offered to eligible  
3 employees using alternative payment methodologies, as defined in ORS  
4 414.025.

5 “(12) No later than December 1 of each calendar year, the board  
6 shall report to the authority, with respect to the self-insured health  
7 benefit plans offered to eligible employees for the next calendar year:

8 “(a) The percentage of total medical expenditures that the board  
9 anticipates spending on primary care;

10 “(b) The percentage of spending on primary care that will be in the  
11 form of alternative payment methodologies; and

12 “(c) The types of alternative payment methodologies that will be  
13 used to reimburse health care providers.

14 “[~~(11)~~] (13) No later than February 1 of each year, the board shall report  
15 to the Legislative Assembly on the board’s progress toward achieving the  
16 *[target of spending at least 12 percent of total medical expenditures in self-*  
17 *insured health benefit plans on payments for primary care]* **spending targets**  
18 **described in subsection (10) of this section and the board’s plan for**  
19 **achieving the targets.**

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

23 “243.135. (1) Notwithstanding any other benefit plan contracted for and  
24 offered by the Public Employees’ Benefit Board, the board shall contract for  
25 a health benefit plan or plans best designed to meet the needs and provide  
26 for the welfare of eligible employees, the state and the local governments.  
27 In considering whether to enter into a contract for a plan, the board shall  
28 place emphasis on:

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

30 “(b) A competitive marketplace;

1 “(c) Plan performance and information;  
2 “(d) Employer flexibility in plan design and contracting;  
3 “(e) Quality customer service;  
4 “(f) Creativity and innovation;  
5 “(g) Plan benefits as part of total employee compensation;  
6 “(h) The improvement of employee health; and  
7 “(i) Health outcome and quality measures, described in ORS 413.017 (4),  
8 that are reported by the plan.

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

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

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

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

30 “(6) Transfer of enrollment from one plan to another shall be open to all

1 eligible employees and their family members under rules adopted by the  
2 board. Because of the special problems that may arise in individual instances  
3 under comprehensive group practice plan coverage involving acceptable  
4 provider-patient relations between a particular panel of providers and par-  
5 ticular eligible employees and their family members, the board shall provide  
6 a procedure under which any eligible employee may apply at any time to  
7 substitute a health service benefit plan for participation in a comprehensive  
8 group practice benefit plan.

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

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

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

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

24 **“(10) The board shall spend at least 12 percent of its total medical**  
25 **expenditures in self-insured health benefit plans on payments for pri-**  
26 **mary care.**

27 **“(11) The board shall reimburse a percentage, as established by rule**  
28 **by the Oregon Health Authority in collaboration with the Department**  
29 **of Consumer and Business Services, of all primary care costs in self-**  
30 **insured health benefit plans offered to eligible employees using alter-**

1 **native payment methodologies, as defined in ORS 414.025.**

2 **“(12) No later than December 1 of each calendar year, the board**  
3 **shall report to the authority, with respect to the self-insured health**  
4 **benefit plans offered to eligible employees for the next calendar year:**

5 **“(a) The percentage of total medical expenditures that the board**  
6 **anticipates spending on primary care;**

7 **“(b) The percentage of spending on primary care that will be in the**  
8 **form of alternative payment methodologies; and**

9 **“(c) The types of alternative payment methodologies that will be**  
10 **used to reimburse health care providers.**

11 **“[(10)] (13) If the board [*spends less than 12 percent of its total medical***  
12 ***expenditures in self-insured health benefit plans on payments for primary***  
13 ***care] fails to meet the financial requirements described in subsection***  
14 **(10) of this section, the board shall implement a plan for increasing, by at**  
15 **least one percent each year:**

16 **“(a) The percentage of total medical expenditures spent on payments for**  
17 **primary care; and**

18 **“(b) The percentage of primary care costs that are reimbursed using**  
19 **alternative payment methodologies [*by at least one percent each year*].**

20 **“[(11)] (14) No later than February 1 of each year, the board shall report**  
21 **to the Legislative Assembly on any plan implemented under subsection**  
22 **[(10)] (13) of this section and on the board’s progress toward achieving the**  
23 **[*target of spending at least 12 percent of total medical expenditures in self-***  
24 ***insured health benefit plans on payments for primary care] financial re-***  
25 **quirements described in subsection (12) of this section.**

26 **“SECTION 7. ORS 243.860 is amended to read:**

27 **“243.860. As used in ORS 243.860 to 243.886, unless the context requires**  
28 **otherwise:**

29 **“(1) ‘Behavioral health clinician’ means:**

30 **“(a) A psychiatrist;**

- 1       **“(b) A psychologist licensed under ORS 675.010 to 675.150;**  
2       **“(c) A nurse practitioner, licensed under ORS 678.375 to 678.390, with**  
3 **a specialty in psychiatric mental health;**  
4       **“(d) A clinical social worker licensed under ORS 675.530;**  
5       **“(e) A marriage and family therapist or professional counselor li-**  
6 **censed under ORS 675.715;**  
7       **“(f) A clinical social work associate certified under ORS 675.537; or**  
8       **“(g) An intern or resident who is working under a board-approved**  
9 **supervisory contract in a clinical mental health field.**

10       **“[(1)] (2) ‘Benefit plan’ includes but is not limited to:**

11       **“(a) Contracts for insurance or other benefits, including medical, dental,**  
12 **vision, life, disability and other health care recognized by state law, and re-**  
13 **lated services and supplies;**

14       **“(b) Self-insurance programs managed by the Oregon Educators Benefit**  
15 **Board; and**

16       **“(c) Comparable benefits for employees who rely on spiritual means of**  
17 **healing.**

18       **“[(2)] (3) ‘Carrier’ means an insurance company or health care service**  
19 **contractor holding a valid certificate of authority from the Director of the**  
20 **Department of Consumer and Business Services, or two or more companies**  
21 **or contractors acting together pursuant to a joint venture, partnership or**  
22 **other joint means of operation, or a board-approved provider or guarantor**  
23 **of benefit plan coverage and compensation.**

24       **“[(3)] (4) ‘District’ means a common school district, a union high school**  
25 **district, an education service district, as defined in ORS 334.003, or a com-**  
26 **munity college district, as defined in ORS 341.005.**

27       **“[(4)(a)] (5)(a) ‘Eligible employee’ includes:**

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

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

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

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

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

13       “(iv) Is eligible to receive a service retirement allowance or pension under  
14 any other retirement benefit plan or system offered by the district or local  
15 government and has attained earliest retirement age under the plan or sys-  
16 tem.

17       “(b) Except as provided in paragraph (a)(B) of this subsection, ‘eligible  
18 employee’ does not include an individual:

19       “(A) Engaged as an independent contractor;

20       “(B) Whose periods of employment in emergency work are on an inter-  
21 mittent or irregular basis; or

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

26       “[(5)] (6) ‘Family member’ means an eligible employee’s spouse or domes-  
27 tic partner and any unmarried child or stepchild of an eligible employee  
28 within age limits and other conditions imposed by the Oregon Educators  
29 Benefit Board with regard to unmarried children or stepchildren.

30       “[(6)] (7) ‘Local government’ means any city, county or special district in

1 this state.

2 **“(8) ‘Patient centered primary care home’ has the meaning given**  
3 **that term in ORS 414.025.**

4 “[7] (9) ‘Payroll disbursing officer’ means the officer or official author-  
5 ized to disburse moneys in payment of salaries and wages of officers and  
6 employees of a district or a local government.

7 “[8] (10) ‘Premium’ means the monthly or other periodic charge, includ-  
8 ing administrative fees of the Oregon Educators Benefit Board, for a benefit  
9 plan.

10 “[9] (11) ‘Primary care’ means family medicine, general internal medi-  
11 cine, naturopathic medicine, *[obstetrics and gynecology,]* pediatrics *[or general*  
12 *psychiatry.]* **and care provided by primary care integrated behavioral**  
13 **health clinicians or primary care integrated women’s health clinicians.**

14 **“(12) ‘Primary care integrated behavioral health clinician’ means:**

15 **“(a) A care team member as defined in ORS 414.025 (15)(b); or**

16 **“(b) A behavioral health clinician providing care to individuals and**  
17 **families in a patient centered primary care home to address one or**  
18 **more of the following:**

19 **“(A) Mental illness.**

20 **“(B) Substance use disorders.**

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

22 **“(D) Life stressors and crises.**

23 **“(E) Developmental risks and conditions.**

24 **“(F) Stress-related physical symptoms.**

25 **“(G) Preventive care.**

26 **“(H) Ineffective patterns of health care utilization.**

27 **“(13) ‘Primary care integrated women’s health clinician’ means one**  
28 **of the following clinicians whose practice is focused on women’s health**  
29 **and primary care and who provides a range of the services within a**  
30 **patient centered primary care home:**

1       **“(a) A physician who is an obstetrician or gynecologist;**

2       **“(b) A nurse practitioner;**

3       **“(c) A physician assistant; or**

4       **“(d) Another health professional licensed or certified in this state.**

5       “[(10)] (14) ‘Total medical expenditures’ means payments to reimburse the  
6 cost of physical and mental health care provided to eligible employees or  
7 their family members, excluding [*prescription drugs,*] vision care and dental  
8 care, whether paid on a fee-for-service basis or as part of a capitated rate  
9 or other type of payment mechanism.

10       **“SECTION 8.** ORS 243.866 is amended to read:

11       “243.866. (1) The Oregon Educators Benefit Board shall contract for ben-  
12 efit plans best designed to meet the needs and provide for the welfare of el-  
13 igible employees, the districts and local governments. In considering whether  
14 to enter into a contract for a benefit plan, the board shall place emphasis  
15 on:

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

17       “(b) Encouragement of a competitive marketplace;

18       “(c) Plan performance and information;

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

21       “(e) Quality customer service;

22       “(f) Creativity and innovation;

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

24       “(h) Improvement of employee health; and

25       “(i) Health outcome and quality measures, described in ORS 413.017 (4),  
26 that are reported by the plan.

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

30       “(3) When appropriate, the board shall provide options under which an

1 eligible employee may arrange coverage for family members under a benefit  
2 plan.

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

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

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

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

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

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

29 **“(10) By January 1, 2020, the board shall reimburse a percentage,**  
30 **as established by rule by the Oregon Health Authority in collaboration**

1 **with the Department of Consumer and Business Services, of all pri-**  
2 **mary care costs in self-insured health benefit plans offered to eligible**  
3 **employees using alternative payment methodologies, as defined in ORS**  
4 **414.025.**

5 **“(11) No later than December 1 of each calendar year, the board**  
6 **shall report to the authority, with respect to the self-insured health**  
7 **benefit plans offered to eligible employees for the next calendar year:**

8 **“(a) The percentage of total medical expenditures that the board**  
9 **anticipates spending on primary care;**

10 **“(b) The percentage of spending on primary care that will be in the**  
11 **form of alternative payment methodologies; and**

12 **“(c) The types of alternative payment methodologies that will be**  
13 **used to reimburse health care providers.**

14 **“[(10)] (12) No later than February 1 of each year, the board shall report**  
15 **to the Legislative Assembly on the board’s progress toward achieving the**  
16 **[target of spending at least 12 percent of total medical expenditures on pay-**  
17 **ments for primary care] **spending targets described in subsection (9) of****  
18 **this section and the board’s plan for achieving the targets.**

19 **“SECTION 9. ORS 243.866, as amended by section 28, chapter 746, Oregon**  
20 **Laws 2017, 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, described in ORS 413.017 (4),  
6 that are reported by the plan.

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

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

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

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

28 “(6) The board shall adopt rules providing that transfer of enrollment  
29 from one benefit plan to another is open to all eligible employees and family  
30 members. Because of the special problems that may arise involving accepta-

1 ble provider-patient relations between a particular panel of providers and a  
2 particular eligible employee or family member under a comprehensive group  
3 practice benefit plan, the board shall provide a procedure under which any  
4 eligible employee may apply at any time to substitute another benefit plan  
5 for participation in a comprehensive group practice benefit plan.

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

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

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

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

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

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

28 **“(12) By January 1, 2020, the board shall reimburse a percentage,**  
29 **as established by rule by the Oregon Health Authority in collaboration**  
30 **with the Department of Consumer and Business Services, of all pri-**

1 **mary care costs in self-insured health benefit plans offered to eligible**  
2 **employees using alternative payment methodologies, as defined in ORS**  
3 **414.025.**

4 **“(13) No later than December 1 of each calendar year, the board**  
5 **shall report to the authority, with respect to the self-insured health**  
6 **benefit plans offered to eligible employees for the next calendar year:**

7 **“(a) The percentage of total medical expenditures that the board**  
8 **anticipates spending on primary care;**

9 **“(b) The percentage of spending on primary care that will be in the**  
10 **form of alternative payment methodologies; and**

11 **“(c) The types of alternative payment methodologies that will be**  
12 **used to reimburse health care providers.**

13 **“[(12)] (14) No later than February 1 of each year, the board shall report**  
14 **to the Legislative Assembly on the board’s progress toward achieving the**  
15 **[target of spending at least 12 percent of total medical expenditures on pay-**  
16 **ments for primary care] spending targets described in subsection (11) of**  
17 **this section and the board’s plan for achieving the targets.**

18 **“SECTION 10.** ORS 243.866, as amended by section 17, chapter 489,  
19 Oregon Laws 2017, and section 28, chapter 746, Oregon Laws 2017, is  
20 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, described in ORS 413.017 (4),  
6 that are reported by the plan.

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

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

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

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

28 “(6) The board shall adopt rules providing that transfer of enrollment  
29 from one benefit plan to another is open to all eligible employees and family  
30 members. Because of the special problems that may arise involving accepta-

1 ble provider-patient relations between a particular panel of providers and a  
2 particular eligible employee or family member under a comprehensive group  
3 practice benefit plan, the board shall provide a procedure under which any  
4 eligible employee may apply at any time to substitute another benefit plan  
5 for participation in a comprehensive group practice benefit plan.

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

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

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

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

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

25 **“(11) The board shall:**

26 **“(a) Spend at least 12 percent of its total medical expenditures in**  
27 **self-insured health benefit plans on payments for primary care; and**

28 **“(b) Reimburse a percentage, as established by rule by the Oregon**  
29 **Health Authority in collaboration with the Department of Consumer**  
30 **and Business Services, of all primary care costs in self-insured health**

1 **benefit plans that are offered to eligible employees using alternative**  
2 **payment methodologies, as defined in ORS 414.025.**

3 “[(11)] **(12)** If the board [*spends less than 12 percent of its total medical*  
4 *expenditures in self-insured health benefit plans on payments for primary*  
5 *care*] **fails to meet the financial requirements described in subsection**  
6 **(11) of this section**, the board shall implement a plan for increasing, **by at**  
7 **least one percent each year:**

8 “(a) The percentage of total medical expenditures spent on payments for  
9 primary care [*by at least one percent each year*]; **and**

10 “(b) **The percentage of primary care costs that are reimbursed using**  
11 **alternative payment methodologies.**

12 “(13) **No later than December 1 of each calendar year, the board**  
13 **shall report to the authority, with respect to the self-insured health**  
14 **benefit plans offered to eligible employees for the next calendar year:**

15 “(a) **The percentage of total medical expenditures that the board**  
16 **anticipates spending on primary care;**

17 “(b) **The percentage of spending on primary care that will be in the**  
18 **form of alternative payment methodologies; and**

19 “(c) **The types of alternative payment methodologies that will be**  
20 **used to reimburse health care providers.**

21 “[(12)] **(14)** No later than February 1 of each year, the board shall report  
22 to the Legislative Assembly on any plan implemented under subsection  
23 [(11)] **(12)** of this section and on the board’s progress toward achieving the  
24 [*target of spending at least 12 percent of total medical expenditures on pay-*  
25 *ments for primary care*] **financial requirements described in subsection**  
26 **(11) of this section.**

27 “**SECTION 10a.** ORS 279A.025 is amended to read:

28 “279A.025. (1) Except as provided in subsections (2) to (4) of this section,  
29 the Public Contracting Code applies to all public contracting.

30 “(2) The Public Contracting Code does not apply to:

1 “(a) Contracts between a contracting agency and:  
2 “(A) Another contracting agency;  
3 “(B) The Oregon Health and Science University;  
4 “(C) A public university listed in ORS 352.002;  
5 “(D) The Oregon State Bar;  
6 “(E) A governmental body of another state;  
7 “(F) The federal government;  
8 “(G) An American Indian tribe or an agency of an American Indian tribe;  
9 “(H) A nation, or a governmental body in a nation, other than the United  
10 States; or  
11 “(I) An intergovernmental entity formed between or among:  
12 “(i) Governmental bodies of this or another state;  
13 “(ii) The federal government;  
14 “(iii) An American Indian tribe or an agency of an American Indian tribe;  
15 “(iv) A nation other than the United States; or  
16 “(v) A governmental body in a nation other than the United States;  
17 “(b) Agreements authorized by ORS chapter 190 or by a statute, charter  
18 provision, ordinance or other authority for establishing agreements between  
19 or among governmental bodies or agencies or tribal governing bodies or  
20 agencies;  
21 “(c) Insurance and service contracts as provided for under ORS 414.115,  
22 414.125, 414.135 and 414.145 for purposes of source selection;  
23 “(d) Grants;  
24 “(e) Contracts for professional or expert witnesses or consultants to pro-  
25 vide services or testimony relating to existing or potential litigation or legal  
26 matters in which a public body is or may become interested;  
27 “(f) Acquisitions or disposals of real property or interest in real property;  
28 “(g) Sole-source expenditures when rates are set by law or ordinance for  
29 purposes of source selection;  
30 “(h) Contracts for the procurement or distribution of textbooks;

1       “(i) Procurements by a contracting agency from an Oregon Corrections  
2 Enterprises program;

3       “(j) The procurement, transportation, sale or distribution of distilled li-  
4 quor, as defined in ORS 471.001, or the appointment of agents under ORS  
5 471.230 or 471.750 by the Oregon Liquor Control Commission;

6       “(k) Contracts entered into under ORS chapter 180 between the Attorney  
7 General and private counsel or special legal assistants;

8       “(L) Contracts for the sale of timber from lands owned or managed by the  
9 State Board of Forestry and the State Forestry Department;

10       “(m) Contracts for activities necessary or convenient for the sale of tim-  
11 ber under paragraph (L) of this subsection, either separately from or in  
12 conjunction with contracts for the sale of timber, including but not limited  
13 to activities such as timber harvesting and sorting, transporting, gravel pit  
14 development or operation, and road construction, maintenance or improve-  
15 ment;

16       “(n) Contracts for forest protection or forest related activities, as de-  
17 scribed in ORS 477.406, by the State Forester or the State Board of Forestry;

18       “(o) Contracts entered into by the Housing and Community Services De-  
19 partment in exercising the department’s duties prescribed in ORS chapters  
20 456 and 458, except that the department’s public contracting for goods and  
21 services is subject to ORS chapter 279B;

22       “(p) Contracts entered into by the State Treasurer in exercising the  
23 powers of that office prescribed in ORS 178.010 to 178.090 and 276A.242 and  
24 ORS chapters 286A, 287A, 289, 293, 294 and 295, including but not limited to  
25 investment contracts and agreements, banking services, clearing house ser-  
26 vices and collateralization agreements, bond documents, certificates of par-  
27 ticipation and other debt repayment agreements, and any associated  
28 contracts, agreements and documents, regardless of whether the obligations  
29 that the contracts, agreements or documents establish are general, special  
30 or limited, except that the State Treasurer’s public contracting for goods and

1 services is subject to ORS chapter 279B;

2 “(q) Contracts, agreements or other documents entered into, issued or es-  
3 tablished in connection with:

4 “(A) The issuance of obligations, as defined in ORS 286A.100 and  
5 287A.310, of a public body;

6 “(B) The making of program loans and similar extensions or advances of  
7 funds, aid or assistance by a public body to a public or private body for the  
8 purpose of carrying out, promoting or sustaining activities or programs au-  
9 thorized by law; or

10 “(C) The investment of funds by a public body as authorized by law, and  
11 other financial transactions of a public body that by their character cannot  
12 practically be established under the competitive contractor selection proce-  
13 dures of ORS 279B.050 to 279B.085;

14 “(r) Contracts for employee benefit plans as provided in ORS 243.105  
15 [(1)] (2), 243.125 (4), 243.221, 243.275, 243.291, 243.303 and 243.565;

16 “(s) Contracts for employee benefit plans as provided in ORS 243.860 to  
17 243.886; or

18 “(t) Any other public contracting of a public body specifically exempted  
19 from the code by another provision of law.

20 “(3) The Public Contracting Code does not apply to the contracting ac-  
21 tivities of:

22 “(a) The Oregon State Lottery Commission;

23 “(b) The legislative department;

24 “(c) The judicial department;

25 “(d) Semi-independent state agencies listed in ORS 182.454, except as  
26 provided in ORS 279.835 to 279.855 and 279A.250 to 279A.290;

27 “(e) Oregon Corrections Enterprises;

28 “(f) The Oregon Film and Video Office, except as provided in ORS  
29 279A.100 and 279A.250 to 279A.290;

30 “(g) The Travel Information Council, except as provided in ORS 279A.250

1 to 279A.290;

2 “(h) The Oregon 529 Savings Network and the Oregon 529 Savings Board;

3 “(i) The Oregon Innovation Council;

4 “(j) The Oregon Utility Notification Center; or

5 “(k) Any other public body specifically exempted from the code by another  
6 provision of law.

7 “(4) ORS 279A.200 to 279A.225 and 279B.050 to 279B.085 do not apply to  
8 contracts made with qualified nonprofit agencies providing employment op-  
9 portunities for individuals with disabilities under ORS 279.835 to 279.855.

10 **“SECTION 11.** ORS 414.653 is amended to read:

11 “414.653. (1) The Oregon Health Authority shall encourage coordinated  
12 care organizations to use alternative payment methodologies that:

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

15 “(b) Hold organizations and providers responsible for the efficient deliv-  
16 ery of quality care;

17 “(c) Reward good performance;

18 “(d) Limit increases in medical costs; and

19 “(e) Use payment structures that create incentives to:

20 “(A) Promote prevention;

21 “(B) Provide person centered care; and

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

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

28 “[3] *A coordinated care organization that participates in a national pri-  
29 mary care medical home payment model, conducted by the Center for Medicare  
30 and Medicaid Innovation in accordance with 42 U.S.C. 1315a, that includes*

1 *performance-based incentive payments for primary care, shall offer similar al-*  
2 *ternative payment methodologies to all patient centered primary care homes*  
3 *identified in accordance with ORS 413.259 that serve members of the coordi-*  
4 *nated care organization.]*

5 “[~~(4)~~] **(3)** The authority shall assist and support coordinated care organ-  
6 izations in identifying cost-cutting measures.

7 “[~~(5)~~] **(4)** If a service provided in a health care facility is not covered by  
8 Medicare because the service is related to a health care acquired condition,  
9 the cost of the service may not be:

10 “(a) Charged by a health care facility or any health services provider  
11 employed by or with privileges at the facility, to a coordinated care organ-  
12 ization, a patient or a third-party payer; or

13 “(b) Reimbursed by a coordinated care organization.

14 “[~~(6)(a)~~] **(5)(a)** Notwithstanding subsections (1) and (2) of this section,  
15 until July 1, 2014, a coordinated care organization that contracts with a Type  
16 A or Type B hospital or a rural critical access hospital, as described in ORS  
17 442.470, shall reimburse the hospital fully for the cost of covered services  
18 based on the cost-to-charge ratio used for each hospital in setting the global  
19 payments to the coordinated care organization for the contract period.

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

24 “(c) The authority shall identify any rural hospital that would not be  
25 expected to remain financially viable if paid in a manner other than as pre-  
26 scribed in paragraphs (a) and (b) of this subsection based upon an evaluation  
27 by an actuary retained by the authority. On and after July 1, 2014, the au-  
28 thority may, on a case-by-case basis, require a coordinated care organization  
29 to continue to reimburse a rural hospital determined to be at financial risk,  
30 in the manner prescribed in paragraphs (a) and (b) of this subsection.

1 “(d) This subsection does not prohibit a coordinated care organization and  
2 a hospital from mutually agreeing to reimbursement other than the re-  
3 imbursement specified in paragraph (a) of this subsection.

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

6 “[7] (6) Notwithstanding subsections (1) and (2) of this section, coordi-  
7 nated care organizations must comply with federal requirements for pay-  
8 ments to providers of Indian health services, including but not limited to the  
9 requirements of 42 U.S.C. 1396j and 42 U.S.C. 1396u-2(a)(2)(C).

10 **“SECTION 12.** ORS 743.010, as amended by section 15, chapter 489,  
11 Oregon Laws 2017, is amended to read:

12 “743.010. (1) In addition to all other powers of the Director of the De-  
13 partment of Consumer and Business Services with respect thereto, the di-  
14 rector may issue rules with respect to policy forms and health benefit plan  
15 forms described in ORS 742.005 (6)(a) and (b):

16 “(a) Establishing minimum benefit standards;

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

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

23 “(d) Establishing requirements *[for]* **to encourage** carriers offering health  
24 benefit plans to:

25 **“(A) Spend at least 12 percent of total medical expenditures on payments**  
26 **for primary care; and**

27 **“(B) Reimburse a percentage, as established by the director by rule,**  
28 **in collaboration with the Oregon Health Authority, of all primary care**  
29 **costs using alternative payment methodologies;**

30 **“(e) Requiring carriers to submit with each rate filing a plan to**

1 increase, by at least one percent each plan year:

2 “(A) The percentage of total medical expenditures spent on pay-  
3 ments for primary care; and

4 “(B) The percentage of primary care costs that are reimbursed us-  
5 ing alternative payment methodologies; and

6 “(f) Requiring carriers to report to the authority, no later than  
7 December 1 of each calendar year, specifying for the next calendar  
8 year:

9 “(A) The percentage of total medical expenditures that the carrier  
10 anticipates spending on primary care;

11 “(B) The percentage of spending on primary care that will be made  
12 using alternative payment methodologies; and

13 “(C) The types of payment methodologies that will be used to re-  
14 imburse health care providers.

15 “(2) As used in this section:

16 “(a) ‘Alternative payment methodology’ has the meaning given that  
17 term in ORS 414.025.

18 “(b) ‘Behavioral health clinician’ means:

19 “(A) A psychiatrist;

20 “(B) A psychologist licensed under ORS 675.010 to 675.150;

21 “(C) A nurse practitioner, licensed under ORS 678.375 to 678.390,  
22 with a specialty in psychiatric mental health;

23 “(D) A clinical social worker licensed under ORS 675.530;

24 “(E) A marriage and family therapist or professional counselor li-  
25 censed under ORS 675.715;

26 “(F) A clinical social work associate certified under ORS 675.537; or

27 “(G) An intern or resident who is working under a board-approved  
28 supervisory contract in a clinical mental health field.

29 “(c) ‘Patient centered primary care home’ has the meaning given  
30 that term in ORS 414.025.

1        “[a] **(d)** ‘Primary care’ means family medicine, general internal medicine,  
2 naturopathic medicine, [*obstetrics and gynecology,*] pediatrics [*or general*  
3 *psychiatry*] **and care provided by primary care integrated behavioral**  
4 **health clinicians or primary care integrated women’s health**  
5 **clinicians.**

6        “**(e)** ‘Primary care integrated behavioral health clinician’ means:

7        “**(A)** A care team member, as defined in ORS 414.025 (15)(b); or

8        “**(B)** A behavioral health clinician providing care to individuals and  
9 **families in a patient centered primary care home to address one or**  
10 **more of the following:**

11        “**(i)** Mental illness.

12        “**(ii)** Substance use disorders.

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

14        “**(iv)** Life stressors and crises.

15        “**(v)** Developmental risks and conditions.

16        “**(vi)** Stress-related physical symptoms.

17        “**(vii)** Preventive care.

18        “**(viii)** Ineffective patterns of health care utilization.

19        “**(f)** ‘Primary care integrated women’s health clinician’ means one  
20 **of the following clinicians whose practice is focused on women’s health**  
21 **and primary care and who provides a range of the services within a**  
22 **patient centered primary care home:**

23        “**(A)** A physician who is an obstetrician or gynecologist;

24        “**(B)** A nurse practitioner;

25        “**(C)** A physician assistant; or

26        “**(D)** Another health professional licensed or certified in this state.

27        “[b] **(g)** ‘Total medical expenditures’ means payments to reimburse the  
28 cost of physical and mental health care provided to enrollees, excluding  
29 [*prescription drugs,*] vision care and dental care, whether paid on a fee-for-  
30 service basis or as part of a capitated rate or other type of payment mech-

1 anism.

2 **“SECTION 13.** ORS 743.010, as amended by section 15, chapter 489,  
3 Oregon Laws 2017, and section 12 of this 2019 Act, is amended to read:

4 “743.010. (1) In addition to all other powers of the Director of the De-  
5 partment of Consumer and Business Services with respect thereto, the di-  
6 rector may issue rules with respect to policy forms and health benefit plan  
7 forms described in ORS 742.005 (6)(a) and (b):

8 “(a) Establishing minimum benefit standards;

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

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

15 “(d) Establishing requirements [*to encourage*] **for** carriers offering health  
16 benefit plans to:

17 “(A) Spend at least 12 percent of total medical expenditures on payments  
18 for primary care; and

19 “(B) Reimburse a percentage, as established by the director by rule, in  
20 collaboration with the Oregon Health Authority, of all primary care costs  
21 using alternative payment methodologies; **and**

22 “[*e*] *Requiring carriers to submit with each rate filing a plan to increase,*  
23 *by at least one percent each plan year.*]

24 “[*A*] *The percentage of total medical expenditures spent on payments for*  
25 *primary care; and*]

26 “[*B*] *The percentage of primary care costs that are reimbursed using al-*  
27 *ternative payment methodologies; and*]

28 “(f) Requiring carriers to report to the authority, no later than December  
29 1 of each calendar year, specifying for the next calendar year:

30 “(A) The percentage of total medical expenditures that the carrier antic-

1 ipates spending on primary care;

2 “(B) The percentage of spending on primary care that will be made using  
3 alternative payment methodologies; and

4 “(C) The types of payment methodologies that will be used to reimburse  
5 health care providers.

6 “(2) As used in this section:

7 “(a) ‘Alternative payment methodology’ has the meaning given that term  
8 in ORS 414.025.

9 “(b) ‘Behavioral health clinician’ means:

10 “(A) A psychiatrist;

11 “(B) A psychologist licensed under ORS 675.010 to 675.150;

12 “(C) A nurse practitioner, licensed under ORS 678.375 to 678.390, with a  
13 specialty in psychiatric mental health;

14 “(D) A clinical social worker licensed under ORS 675.530;

15 “(E) A marriage and family therapist or professional counselor licensed  
16 under ORS 675.715;

17 “(F) A clinical social work associate certified under ORS 675.537; or

18 “(G) An intern or resident who is working under a board-approved su-  
19 pervisory contract in a clinical mental health field.

20 “(c) ‘Patient centered primary care home’ has the meaning given that  
21 term in ORS 414.025.

22 “(d) ‘Primary care’ means family medicine, general internal medicine,  
23 naturopathic medicine, pediatrics and care provided by primary care inte-  
24 grated behavioral health clinicians or primary care integrated women’s  
25 health clinicians.

26 “(e) ‘Primary care integrated behavioral health clinician’ means:

27 “(A) A care team member, as defined in ORS 414.025 (15)(b); or

28 “(B) A behavioral health clinician providing care to individuals and fam-  
29 ilies in a patient centered primary care home to address one or more of the  
30 following:

1       “(i) Mental illness.  
2       “(ii) Substance use disorders.  
3       “(iii) Health behaviors that contribute to chronic illness.  
4       “(iv) Life stressors and crises.  
5       “(v) Developmental risks and conditions.  
6       “(vi) Stress-related physical symptoms.  
7       “(vii) Preventive care.  
8       “(viii) Ineffective patterns of health care utilization.  
9       “(f) ‘Primary care integrated women’s health clinician’ means one of the  
10 following clinicians whose practice is focused on women’s health and pri-  
11 mary care and who provides a range of the services within a patient centered  
12 primary care home:  
13       “(A) A physician who is an obstetrician or gynecologist;  
14       “(B) A nurse practitioner;  
15       “(C) A physician assistant; or  
16       “(D) Another health professional licensed or certified in this state.  
17       “(g) ‘Total medical expenditures’ means payments to reimburse the cost  
18 of physical and mental health care provided to enrollees, excluding vision  
19 care and dental care, whether paid on a fee-for-service basis or as part of a  
20 capitated rate or other type of payment mechanism.  
21       “**SECTION 14.** Section 1, chapter 575, Oregon Laws 2015, as amended by  
22 section 12, chapter 489, Oregon Laws 2017, is amended to read:  
23       “**Sec. 1.** (1) As used in this section:  
24       “(a) ‘Carrier’ means an insurer that offers a health benefit plan, as de-  
25 fined in ORS 743B.005.  
26       “(b) ‘Prominent carrier’ means:  
27       “(A) A carrier with annual premium income at a threshold, of no less  
28 than \$50 million, established by the Department of Consumer and Business  
29 Services by rule.  
30       “(B) The Public Employees’ Benefit Board.

1 “(C) The Oregon Educators Benefit Board.

2 “(2) All prominent carriers shall, and carriers other than prominent car-  
3 riers may, report to the Department of Consumer and Business Services, no  
4 later than October 1 of each year, the proportion of the carrier’s total med-  
5 ical [*expenses*] **expenditures** that are allocated to primary care.

6 “(3) The department shall share with the Oregon Health Authority the  
7 information reported so that the authority may prepare the evaluation and  
8 [*report*] **reports** described in [*section 2*] **sections 2 and 3**, chapter 575,  
9 Oregon Laws 2015.

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

13 **“SECTION 15.** Section 2, chapter 575, Oregon Laws 2015, as amended by  
14 section 1, chapter 384, Oregon Laws 2017, and section 13, chapter 489, Oregon  
15 Laws 2017, is amended to read:

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

17 **“(a) ‘Behavioral health clinician’ means:**

18 **“(A) A psychiatrist;**

19 **“(B) A psychologist licensed under ORS 675.010 to 675.150;**

20 **“(C) A nurse practitioner, licensed under ORS 678.375 to 678.390,**  
21 **with a specialty in psychiatric mental health;**

22 **“(D) A clinical social worker licensed under ORS 675.530;**

23 **“(E) A marriage and family therapist or professional counselor li-**  
24 **censed under ORS 675.715;**

25 **“(F) A clinical social work associate certified under ORS 675.537; or**

26 **“(G) An intern or resident who is working under a board-approved**  
27 **supervisory contract in a clinical mental health field.**

28 **“[(a)] (b) ‘Carrier’ means an insurer that offers a health benefit plan, as**  
29 **defined in ORS 743B.005.**

30 **“[(b)] (c) ‘Coordinated care organization’ has the meaning given that term**

1 in ORS 414.025.

2 **“(d) ‘Patient centered primary care home’ has the meaning given**  
3 **that term in ORS 414.025.**

4 **“[(c)] (e) ‘Primary care’ means family medicine, general internal medicine,**  
5 **naturopathic medicine, [obstetrics and gynecology,] pediatrics [or general**  
6 **psychiatry] and care provided by primary care integrated behavioral**  
7 **health clinicians or primary care integrated women’s health**  
8 **clinicians.**

9 **“(f) ‘Primary care integrated behavioral health clinician’ means:**

10 **“(A) A care team member as defined in ORS 414.025 (15)(b); or**

11 **“(B) A behavioral health clinician providing care to individuals and**  
12 **families in a patient centered primary care home to address one or**  
13 **more of the following:**

14 **“(i) Mental illness.**

15 **“(ii) Substance use disorders.**

16 **“(iii) Health behaviors that contribute to chronic illness.**

17 **“(iv) Life stressors and crises.**

18 **“(v) Developmental risks and conditions.**

19 **“(vi) Stress-related physical symptoms.**

20 **“(vii) Preventive care.**

21 **“(viii) Ineffective patterns of health care utilization.**

22 **“(g) ‘Primary care integrated women’s health clinician’ means one**  
23 **of the following clinicians whose practice is focused on women’s health**  
24 **and primary care and who provides a range of the services within a**  
25 **patient centered primary care home:**

26 **“(A) A physician who is an obstetrician or gynecologist;**

27 **“(B) A nurse practitioner;**

28 **“(C) A physician assistant; or**

29 **“(D) Another health professional licensed or certified in this state.**

30 **“[(d)] (h) ‘Primary care provider’ includes:**

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

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

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

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

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

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

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

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

17 “(C) Provide technical assistance to clinics and payers in implementing  
18 the initiative;

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

22 “(E) Facilitate the integration of primary care behavioral and physical  
23 health care; and

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

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

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

28 “(a) Primary care providers;

29 “(b) Health care consumers;

30 “(c) Experts in primary care contracting and reimbursement;

1 “(d) Independent practice associations;  
2 “(e) Behavioral health treatment providers;  
3 “(f) Third party administrators;  
4 “(g) Employers that offer self-insured health benefit plans;  
5 “(h) The Department of Consumer and Business Services;  
6 “(i) Carriers;  
7 “(j) A statewide organization for mental health professionals who provide  
8 primary care;  
9 “(k) A statewide organization representing federally qualified health cen-  
10 ters;  
11 “(L) A statewide organization representing hospitals and health systems;  
12 “(m) A statewide professional association for family physicians;  
13 “(n) A statewide professional association for physicians;  
14 “(o) A statewide professional association for nurses; and  
15 “(p) The Centers for Medicare and Medicaid Services.  
16 “(4) The primary care payment reform collaborative shall annually report  
17 to the Oregon Health Policy Board and to the Legislative Assembly on the  
18 achievement of the primary care [*spending targets*] **financial requirements**  
19 in ORS 414.625 and 743.010 and the implementation of the Primary Care  
20 Transformation Initiative.  
21 “(5) A coordinated care organization shall report to the authority, no  
22 later than October 1 of each year, the proportion of the organization’s total  
23 medical [*costs*] **expenditures** that are allocated to primary care.  
24 “(6) The authority, in collaboration with the Department of Consumer and  
25 Business Services, shall adopt rules prescribing the primary care services for  
26 which costs must be reported under subsection (5) of this section.  
27 **“SECTION 16.** Section 3, chapter 575, Oregon Laws 2015, as amended by  
28 section 7, chapter 26, Oregon Laws 2016, is amended to read:  
29 **“Sec. 3.** No later than February 1 of each year, the Oregon Health Au-  
30 thority and the Department of Consumer and Business Services shall report

1 to the Legislative Assembly, in the manner provided in ORS 192.245:

2 “(1) The percentage of the medical expenses of carriers, coordinated care  
3 organizations, the Public Employees’ Benefit Board and the Oregon Educa-  
4 tors Benefit Board that is allocated to primary care; [and]

5 “(2) How carriers, coordinated care organizations, the Public Employees’  
6 Benefit Board and the Oregon Educators Benefit Board pay for primary  
7 care; **and**

8 **“(3) As reported to the authority and the Department of Consumer**  
9 **and Business Services under ORS 243.135 and 243.866 and section 2 of**  
10 **this 2019 Act:**

11 **“(a) The percentage of total medical expenditures that carriers,**  
12 **coordinated care organizations, the Oregon Educators Benefit Board**  
13 **and the Public Employees’ Benefit Board anticipate spending on pri-**  
14 **mary care for the calendar year;**

15 **“(b) The percentage of spending on primary care by carriers, coor-**  
16 **dated care organizations, the Oregon Educators Benefit Board and**  
17 **the Public Employees’ Benefit Board that will be in the form of alter-**  
18 **native payment methodologies, as defined in ORS 414.025, in the cal-**  
19 **endar year; and**

20 **“(c) The types of alternative payment methodologies that carriers,**  
21 **coordinated care organizations, the Oregon Educators Benefit Board**  
22 **and the Public Employees’ Benefit Board will use in the calendar year.**

23 **“SECTION 17.** Section 2 of this 2019 Act is amended to read:

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

25 “(a) ‘Behavioral health clinician’ means:

26 “(A) A psychiatrist;

27 “(B) A psychologist licensed under ORS 675.010 to 675.150;

28 “(C) A nurse practitioner, licensed under ORS 678.375 to 678.390, with a  
29 specialty in psychiatric mental health;

30 “(D) A clinical social worker licensed under ORS 675.530;

1 “(E) A marriage and family therapist or professional counselor licensed  
2 under ORS 675.715;

3 “(F) A clinical social work associate certified under ORS 675.537; or

4 “(G) An intern or resident who is working under a board-approved su-  
5 pervisory contract in a clinical mental health field.

6 “(b) ‘Primary care’ means family medicine, general internal medicine,  
7 naturopathic medicine, pediatrics and care provided by primary care inte-  
8 grated behavioral health clinicians or primary care integrated women’s  
9 health clinicians.

10 “(c) ‘Primary care integrated behavioral health clinician’ means:

11 “(A) A care team member as defined in ORs 414.025 (15)(b); or

12 “(B) A behavioral health clinician providing care to individuals and fam-  
13 ilies in a patient centered primary care home to address one or more of the  
14 following:

15 “(i) Mental illness.

16 “(ii) Substance use disorders.

17 “(iii) Health behaviors that contribute to chronic illness.

18 “(iv) Life stressors and crises.

19 “(v) Developmental risks and conditions.

20 “(vi) Stress-related physical symptoms.

21 “(vii) Preventive care.

22 “(viii) Ineffective patterns of health care utilization.

23 “(d) ‘Primary care integrated women’s health clinician’ means one of the  
24 following clinicians whose practice is focused on women’s health and pri-  
25 mary care and who provides a range of the services within a patient centered  
26 primary care home:

27 “(A) A physician who is an obstetrician or gynecologist;

28 “(B) A nurse practitioner;

29 “(C) A physician assistant; or

30 “(D) Another health professional licensed or certified in this state.

1 “(e) ‘Total medical expenditures’ means total expenditures for physical  
2 and mental health care provided to members of a coordinated care organ-  
3 ization, excluding expenditures for vision care and dental care.

4 “(2) [*No later than January 1, 2023,*] A coordinated care organization must  
5 spend at least 12 percent of the coordinated care organization’s total medical  
6 expenditures on primary care.

7 “(3) [*No later than January 1, 2020,*] A coordinated care organization must  
8 reimburse a percentage, as established by the Oregon Health Authority by  
9 rule, of all primary care costs using alternative payment methodologies.

10 “(4) After the Oregon Health Authority has established a global budget  
11 for a coordinated care organization for a calendar year, the coordinated care  
12 organization shall report to the authority, at the time and in the manner  
13 prescribed by the authority by rule:

14 “(a) The percentage of the global budget that the coordinated care or-  
15 ganization anticipates spending on primary care;

16 “(b) The percentage of the spending on primary care that will be in the  
17 form of alternative payment methodologies; and

18 “(c) The types of alternative payment methodologies that the coordinated  
19 care organization will use during the calendar year.”.

20 On page 24, line 27, after “(2)” insert “and (3)”.

21 In line 43, delete “15” and insert “14”.

22 In line 45, delete “16” and insert “15”.

23 On page 25, line 3, after the first comma insert “and section 16 of this  
24 2019 Act”.

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