

HB 2267-2  
(LC 372)  
4/2/19 (LHF/ps)

Requested by HOUSE COMMITTEE ON HEALTH CARE (at the request of the Oregon Health Authority)

**PROPOSED AMENDMENTS TO  
HOUSE BILL 2267**

1 In line 2 of the printed bill, before the period insert “; creating new pro-  
2 visions; and amending ORS 183.310, 414.065, 414.625, 414.627, 414.629 and  
3 414.652”.

4 Delete lines 4 through 7 and insert:

5 **“SECTION 1. (1) A coordinated care organization shall collaborate**  
6 **with local public health authorities and hospitals located in areas**  
7 **served by the coordinated care organization to conduct a community**  
8 **health assessment and adopt a community health improvement plan,**  
9 **shared with and endorsed by the coordinated care organization, local**  
10 **public health authorities and hospitals, to serve as a strategic popu-**  
11 **lation health and health care services plan for the residents of the**  
12 **areas served by the coordinated care organization, local public health**  
13 **authorities and hospitals. The health improvement plan must include**  
14 **strategies for achieving shared priorities.**

15 **“(2) The coordinated care organization shall post the health im-**  
16 **provement plan to the coordinated care organization’s website.**

17 **“(3) The Oregon Health Authority may prescribe by rule require-**  
18 **ments for health improvement plans and provide guidance for aligning**  
19 **the timelines for the development of the community health assess-**  
20 **ments and health improvement plans by coordinated care organiza-**  
21 **tions, local public health authorities and hospitals.**

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

2       **“(a) ‘Attachment point’ means the threshold dollar amount,**  
3 **adopted by the Oregon Health Authority by rule, for costs incurred by**  
4 **a coordinated care organization in a calendar year for a member, after**  
5 **which threshold the costs are eligible for state reinsurance payments.**

6       **“(b) ‘Coinsurance rate’ means the rate, adopted by the authority**  
7 **by rule, at which the authority will reimburse a coordinated care or-**  
8 **ganization for costs incurred by the coordinated care organization in**  
9 **a calendar year after the attachment point and before the reinsurance**  
10 **cap.**

11       **“(c) ‘Reinsurance’ has the meaning given that term in ORS 731.126.**

12       **“(d) ‘Reinsurance cap’ means the maximum dollar amount, adopted**  
13 **by the authority by rule, for costs incurred by a coordinated care or-**  
14 **ganization in a calendar year, after which maximum the costs are no**  
15 **longer eligible for state reinsurance payments.**

16       **“(e) ‘Reinsurance payment’ means a payment by the reinsurance**  
17 **program described in subsection (2) of this section to cover part of a**  
18 **coordinated care organization’s costs.**

19       **“(2) The Oregon Health Authority may establish a reinsurance**  
20 **program to:**

21       **“(a) Make payments to coordinated care organizations that face**  
22 **particularly high costs in caring for members who require new, ex-**  
23 **ceptionally costly drugs or treatments; and**

24       **“(b) Better manage costs systemically.**

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

27       **“(a) A coordinated care organization becomes eligible for a rein-**  
28 **surance payment when the coordinated care organization’s costs in a**  
29 **calendar year exceed the attachment point. The amount of the pay-**  
30 **ment shall be the product of the coinsurance rate and the coordinated**

1 care organization’s costs that exceed the attachment point, up to the  
2 reinsurance cap.

3 “(b) After the authority adopts by rule the attachment point, rein-  
4 surance cap or coinsurance rate for a calendar year, the authority may  
5 not:

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

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

9 “(c) The authority may adopt rules necessary to carry out the pro-  
10 visions of this section including, but not limited to, rules prescribing:

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

12 “(B) Assessments, if any, necessary to provide funding for the pro-  
13 gram; and

14 “(C) Financial reporting requirements for coordinated care organ-  
15 izations necessary to administer the program.

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

19 “(4) The authority shall work with the Centers for Medicare and  
20 Medicaid Services in establishing a reinsurance program under sub-  
21 section (2) of this section to ensure compliance with federal require-  
22 ments and federal financial participation in the costs of the program.

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

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

28 “(b) Oversee the tribal liaisons in each coordinated care organiza-  
29 tion, described in ORS 414.625 (2)(q), and work with coordinated care  
30 organizations.

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

6       **“(3) The term of office of each member of the council is four years,**  
7 **but a member serves at the pleasure of the Indian tribe that appointed**  
8 **the member. Before the expiration of the term of a member, the tribe**  
9 **that appointed the member shall appoint a successor whose term be-**  
10 **gins on January 1 next following. A member is eligible for reappoint-**  
11 **ment. If there is a vacancy for any cause, the vacancy shall be filled**  
12 **by the appointing tribe to become immediately effective for the unex-**  
13 **pired term.**

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

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

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

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

27       **“(8) The Oregon Health Authority shall provide staff support to the**  
28 **council.**

29       **“SECTION 4. ORS 183.310 is amended to read:**

30       **“183.310. As used in this chapter:**

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

4 “(2)(a) ‘Contested case’ means a proceeding before an agency:

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

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

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

13 “(D) Where the agency by rule or order provides for hearings substan-  
14 tially of the character required by ORS 183.415, 183.417, 183.425, 183.450,  
15 183.460 and 183.470.

16 “(b) ‘Contested case’ does not include proceedings in which an agency  
17 decision rests solely on the result of a test.

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

21 “(4) ‘Hearing officer’ includes an administrative law judge.

22 “(5) ‘License’ includes the whole or part of any agency permit, certificate,  
23 approval, registration or similar form of permission required by law to pur-  
24 sue any commercial activity, trade, occupation or profession.

25 “(6)(a) ‘Order’ means any agency action expressed orally or in writing  
26 directed to a named person or named persons, other than employees, officers  
27 or members of an agency. ‘Order’ includes any agency determination or de-  
28 cision issued in connection with a contested case proceeding. ‘Order’ in-  
29 cludes:

30 “(A) Agency action under ORS chapter 657 making determination for

1 purposes of unemployment compensation of employees of the state;

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

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

5 “(b) ‘Final order’ means final agency action expressed in writing. ‘Final  
6 order’ does not include any tentative or preliminary agency declaration or  
7 statement that:

8 “(A) Precedes final agency action; or

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

11 “(7) ‘Party’ means:

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

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

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

21 “(8) ‘Person’ means any individual, partnership, corporation, association,  
22 governmental subdivision or public or private organization of any character  
23 other than an agency.

24 “(9) ‘Rule’ means any agency directive, standard, regulation or statement  
25 of general applicability that implements, interprets or prescribes law or pol-  
26 icy, or describes the procedure or practice requirements of any agency. The  
27 term includes the amendment or repeal of a prior rule, but does not include:

28 “(a) Unless a hearing is required by statute, internal management direc-  
29 tives, regulations or statements which do not substantially affect the inter-  
30 ests of the public:

1 “(A) Between agencies, or their officers or their employees; or  
2 “(B) Within an agency, between its officers or between employees.  
3 “(b) Action by agencies directed to other agencies or other units of gov-  
4 ernment which do not substantially affect the interests of the public.  
5 “(c) Declaratory rulings issued pursuant to ORS 183.410 or 305.105.  
6 “(d) Intra-agency memoranda.  
7 “(e) Executive orders of the Governor.  
8 “(f) Rules of conduct for persons committed to the physical and legal  
9 custody of the Department of Corrections, the violation of which will not  
10 result in:  
11 “(A) Placement in segregation or isolation status in excess of seven days.  
12 “(B) Institutional transfer or other transfer to secure confinement status  
13 for disciplinary reasons.  
14 “(C) Disciplinary procedures adopted pursuant to ORS 421.180.  
15 “(10)(a) ‘Small business’ means a corporation, partnership, sole  
16 proprietorship or other legal entity formed for the purpose of making a pro-  
17 fit, which is independently owned and operated from all other businesses and  
18 which has 50 or fewer employees.  
19 “(b) **‘Small business’ does not include a coordinated care organiza-**  
20 **tion as defined in ORS 414.025.**  
21 **“SECTION 5.** ORS 414.065 is amended to read:  
22 “414.065. (1)(a) With respect to health care and services to be provided in  
23 medical assistance during any period, the Oregon Health Authority shall  
24 determine, subject to such revisions as it may make from time to time and  
25 subject to legislative funding and paragraph (b) of this subsection:  
26 “(A) The types and extent of health care and services to be provided to  
27 each eligible group of recipients of medical assistance.  
28 “(B) Standards, including outcome and quality measures, to be observed  
29 in the provision of health care and services.  
30 “(C) The number of days of health care and services toward the cost of

1 which medical assistance funds will be expended in the care of any person.

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

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

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

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

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

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

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

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

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

28 “(b) The authority shall consider the community health assessment con-  
29 ducted by the organization **in accordance with section 1 of this 2019 Act**  
30 and reviewed annually, and the organization’s health care costs; and

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

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

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

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

11       “**SECTION 6.** ORS 414.625, as amended by section 3, chapter 49, Oregon  
12 Laws 2018, is amended to read:

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

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

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

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

1 abilities above \$250,000.

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

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

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

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

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

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

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

30 “(a) Each member of the coordinated care organization receives integrated

1 person centered care and services designed to provide choice, independence  
2 and dignity.

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

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

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

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

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

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

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

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

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

1 aging appropriate preventive, health, remedial and supportive care and ser-  
2 vices, including the services described in ORS 414.766, to reduce the use of  
3 avoidable emergency room visits and hospital admissions.

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

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

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

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

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

16 “(E) Include providers of specialty care.

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

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

23 “(L) Each coordinated care organization reports on outcome and quality  
24 measures adopted under ORS 414.638 and participates in the health care data  
25 reporting system 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*] **two members** of the community advisory  
16 council, **one of whom is or was within the previous six months a re-**  
17 **ipient of medical assistance and is at least 16 years of age, or a par-**  
18 **ent, guardian or primary caregiver of an individual who is or was**  
19 **within the previous six months a recipient of medical assistance.**

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

24 “(q) **Each coordinated care organization works with the Tribal Ad-**  
25 **visory Council established in section 3 of this 2019 Act and has a ded-**  
26 **icated tribal liaison, selected by the council, to:**

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

30 “(B) **Participate in the community health assessment and the de-**

1 **velopment of the health improvement plan;**

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

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

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

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

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

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

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

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

24 **“SECTION 7.** ORS 414.625, as amended by section 14, chapter 489, Oregon  
25 Laws 2017, and section 4, chapter 49, Oregon Laws 2018, is amended to read:

26 “414.625. (1) The Oregon Health Authority shall adopt by rule the quali-  
27 fication criteria and requirements for a coordinated care organization and  
28 shall integrate the criteria and requirements into each contract with a co-  
29 ordinated care organization. Coordinated care organizations may be local,  
30 community-based organizations or statewide organizations with community-

1 based participation in governance or any combination of the two. Coordi-  
2 nated care organizations may contract with counties or with other public or  
3 private entities to provide services to members. The authority may not con-  
4 tract with only one statewide organization. A coordinated care organization  
5 may be a single corporate structure or a network of providers organized  
6 through contractual relationships. The criteria and requirements adopted by  
7 the authority under this section must include, but are not limited to, a re-  
8 quirement that the coordinated care organization:

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

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

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

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

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

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

30 “(d) Develop and implement alternative payment methodologies that are

1 based on health care quality and improved health outcomes.

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

5 “(f) Engage community members and health care providers in improving  
6 the health of the community and addressing regional, cultural, socioeconomic  
7 and racial disparities in health care that exist among the coordinated care  
8 organization’s members and in the coordinated care organization’s commu-  
9 nity.

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

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

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

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

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

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

30 “(f) Services and supports are geographically located as close to where

1 members reside as possible and are, if available, offered in nontraditional  
2 settings that are accessible to families, diverse communities and underserved  
3 populations.

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

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

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

11 “(j) Each coordinated care organization prioritizes working with members  
12 who have high health care needs, multiple chronic conditions, mental illness  
13 or chemical dependency and involves those members in accessing and man-  
14 aging appropriate preventive, health, remedial and supportive care and ser-  
15 vices, including the services described in ORS 414.766, to reduce the use of  
16 avoidable emergency room visits and hospital admissions.

17 “(k) Members have a choice of providers within the coordinated care  
18 organization’s network and that providers participating in a coordinated care  
19 organization:

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

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

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

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

29 “(E) Include providers of specialty care.

30 “(F) Are selected by coordinated care organizations using universal ap-

1 plication and credentialing procedures and objective quality information and  
2 are removed if the providers fail to meet objective quality standards.

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

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

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

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

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

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

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

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

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

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

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

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

28 “(F) At least [*one member*] **two members** of the community advisory  
29 council, **one of whom is or was within the previous six months a re-**  
30 **recipient of medical assistance and is at least 16 years of age or a parent,**

1 **guardian or primary caregiver of an individual who is or was within**  
2 **the previous six months a recipient of medical assistance.**

3 “(p) Each coordinated care organization’s governing body establishes  
4 standards for publicizing the activities of the coordinated care organization  
5 and the organization’s community advisory councils, as necessary, to keep  
6 the community informed.

7 **“(q) Each coordinated care organization works with the Tribal Ad-**  
8 **visory Council established in section 3 of this 2019 Act and has a ded-**  
9 **icated tribal liaison, selected by the council, to:**

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

13 **“(B) Participate in the community health assessment and the de-**  
14 **velopment of the health improvement plan;**

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

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

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

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

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

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

30 “(c) Allow more than one coordinated care organization to serve the ge-

1 ographic area if necessary to optimize access and choice under this sub-  
2 section.

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

7 **“SECTION 8.** ORS 414.627 is amended to read:

8 “414.627. (1) A coordinated care organization must have a community ad-  
9 visory council to ensure that the health care needs of the consumers and the  
10 community are being addressed. The council must:

11 “(a) Include representatives of the community and of each county gov-  
12 ernment served by the coordinated care organization, but consumer repre-  
13 sentatives must constitute a majority of the membership; and

14 “(b) Have its membership selected by a committee composed of equal  
15 numbers of county representatives from each county served by the coordi-  
16 nated care organization and members of the governing body of the coordi-  
17 nated care organization.

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

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

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

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

27 “(3) The community health improvement plan adopted by the council  
28 should describe the scope of the activities, services and responsibilities that  
29 the coordinated care organization will consider upon implementation of the  
30 plan. The activities, services and responsibilities defined in the plan shall

1 include a plan and a strategy for integrating physical, behavioral and oral  
2 health care services and may include, but are not limited to:

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

6 “(b) Health policy;

7 “(c) System design;

8 “(d) Outcome and quality improvement;

9 “(e) Integration of service delivery; and

10 “(f) Workforce development.

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

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

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

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

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

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

30 “(6) The coordinated care organization shall post to the organization’s

1 website contact information for, at a minimum, the chairperson, a member  
2 of the community advisory council or a designated staff member of the or-  
3 ganization.

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

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

7 “414.652. (1) As used in this section:

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

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

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

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

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

20 “(c) May be terminated by the authority if a coordinated care organiza-  
21 tion fails to meet outcome and quality measures specified in the contract or  
22 is otherwise in breach of the contract.

23 “(3) This section does not prohibit the authority from allowing a coordi-  
24 nated care organization a reasonable amount of time in which to cure any  
25 failure to meet outcome and quality measures specified in the contract prior  
26 to the termination of the contract.

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

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

30 “[a)] (A) The authority and the coordinated care organization mutually

1 agree to amend the contract; or

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

3 **“(b) Once within the first eight months of the effective date of the**  
4 **contract if needed to adjust the global budget of a coordinated care**  
5 **organization, retroactive to the beginning of the calendar year, to take**  
6 **into account changes in the membership of the coordinated care or-**  
7 **ganization or the health status of the coordinated care organization’s**  
8 **members.**

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

13 **“(6) Except as provided in subsection (4)(b) of this section,** an  
14 amendment to a contract may apply retroactively only if:

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

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

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

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

1 benefit period.

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

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

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

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

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

17 **“SECTION 10.** ORS 414.629 is amended to read:

18 “414.629. (1) A community health improvement plan adopted by a coordi-  
19 nated care organization and its community advisory council in accordance  
20 with [ORS 414.627] **section 1 of this 2019 Act** shall include **a component**  
21 **for addressing the health of children and youth in the areas served by**  
22 **the coordinated care organization including**, to the extent practicable, a  
23 strategy and a plan for:

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

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

29 “(2) A community health improvement plan must be based on research,  
30 including research into adverse childhood experiences, and must identify

1 funding sources and additional funding necessary to address the health needs  
2 of children and adolescents in the community and to meet the goals of the  
3 plan. The plan must also:

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

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

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

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

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

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

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

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

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

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

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

27 “(e) Relief nurseries in the region;

28 “(f) Community health centers;

29 “(g) Oral health care providers;

30 “(h) Community mental health providers;

1 “(i) Administrators of county health department programs that offer pre-  
2 ventive health services to children;

3 “(j) Hospitals in the region; and

4 “(k) Other appropriate child and adolescent health program administra-  
5 tors.

6 “(4) The Oregon Health Authority may provide incentive grants to coor-  
7 dinated care organizations for the purpose of contracting with individuals  
8 or organizations to help coordinate integration strategies identified in the  
9 community health improvement plan adopted by the community advisory  
10 council. The authority may also provide funds to coordinated care organiza-  
11 tions to improve systems of services that will promote the implementation  
12 of the plan.

13 “(5) Each coordinated care organization shall report to the authority, in  
14 the form and manner prescribed by the authority, on the progress of the in-  
15 tegration strategies and implementation of the plan for working with the  
16 programs developed by the Early Learning Council, Early Learning Hubs,  
17 the Youth Development Council and school health care providers in the re-  
18 gion, as part of the development and implementation of the community  
19 health improvement plan. The authority shall compile the information  
20 biennially and report the information to the Legislative Assembly by De-  
21 cember 31 of each even-numbered year.”.

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