

House Bill 3094

Sponsored by Representative PRUSAK; Senator PATTERSON

SUMMARY

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

Requires insurers contracting with Public Employees' Benefit Board and Oregon Educators Benefit Board and coordinated care organizations contracting with Oregon Health Authority to enter into voluntary agreement with authority to take steps to achieve target percentage of all payments to providers being made using value-based payment methods.

A BILL FOR AN ACT

1
2 Relating to paying for health care; amending ORS 243.135, 243.866 and 414.572.

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

4 **SECTION 1.** ORS 243.135 is amended to read:

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

10 (a) Employee choice among high quality plans;

11 (b) A competitive marketplace;

12 (c) Plan performance and information;

13 (d) Employer flexibility in plan design and contracting;

14 (e) Quality customer service;

15 (f) Creativity and innovation;

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

17 (h) The improvement of employee health; and

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

20 (2) The board may approve more than one carrier for each type of plan contracted for and of-
21 fered but the number of carriers shall be held to a number consistent with adequate service to eli-
22 gible employees and their family members.

23 (3) Where appropriate for a contracted and offered health benefit plan, the board shall provide
24 options under which an eligible employee may arrange coverage for family members. The board shall
25 impose a surcharge in an amount determined by the board on an eligible employee who arranges
26 coverage for the employee's spouse or dependent under this subsection if the spouse or dependent
27 has access to medical coverage as an employee in another health benefit plan offered by the board
28 or the Oregon Educators Benefit Board.

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

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

1 in the plan or plans selected and the deduction of a certain sum from the employee's pay.

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

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

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

13 (8)(a) The board shall use payment methodologies in self-insured health benefit plans offered by
14 the board that are designed to limit the growth in per-member expenditures for health services to
15 no more than 3.4 percent per year. The assessment paid in accordance with section 3, chapter 538,
16 Oregon Laws 2017, shall be excluded in determining the 3.4 percent annual increase in per-member
17 expenditures for health services.

18 (b) The board shall adopt policies and practices designed to limit the annual increase in pre-
19 mium amounts paid for contracted health benefit plans to 3.4 percent, **including but not limited**
20 **to contracting only with insurers that voluntarily sign a compact or enter into another form**
21 **of agreement with the Oregon Health Authority committing to take steps to achieve a target**
22 **percentage of all payments to providers being made using value-based payment methods in-**
23 **stead of the fee-for-service method.**

24 (9) As frequently as is recommended as a commercial best practice by consultants engaged by
25 the board, the board shall conduct an audit of the health benefit plan enrollees' continued eligibility
26 for coverage as spouses or dependents or any other basis that would affect the cost of the premium
27 for the plan.

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

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

33 **SECTION 2.** ORS 243.135, as amended by section 16, chapter 489, Oregon Laws 2017, section
34 12, chapter 2, Oregon Laws 2019, and section 2, chapter 484, Oregon Laws 2019, is amended to read:

35 243.135. (1) Notwithstanding any other benefit plan contracted for and offered by the Public
36 Employees' Benefit Board, the board shall contract for a health benefit plan or plans best designed
37 to meet the needs and provide for the welfare of eligible employees, the state and the local gov-
38 ernments. In considering whether to enter into a contract for a plan, the board shall place emphasis
39 on:

- 40 (a) Employee choice among high quality plans;
- 41 (b) A competitive marketplace;
- 42 (c) Plan performance and information;
- 43 (d) Employer flexibility in plan design and contracting;
- 44 (e) Quality customer service;
- 45 (f) Creativity and innovation;

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

2 (h) The improvement of employee health; and

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

5 (2) The board may approve more than one carrier for each type of plan contracted for and of-
6 fered but the number of carriers shall be held to a number consistent with adequate service to eli-
7 gible employees and their family members.

8 (3) Where appropriate for a contracted and offered health benefit plan, the board shall provide
9 options under which an eligible employee may arrange coverage for family members. The board shall
10 impose a surcharge in an amount determined by the board on an eligible employee who arranges
11 coverage for the employee's spouse or dependent under this subsection if the spouse or dependent
12 has access to medical coverage as an employee in another health benefit plan offered by the board
13 or the Oregon Educators Benefit Board.

14 (4) Payroll deductions for costs that are not payable by the state or a local government may be
15 made upon receipt of a signed authorization from the employee indicating an election to participate
16 in the plan or plans selected and the deduction of a certain sum from the employee's pay.

17 (5) In developing any health benefit plan, the board may provide an option of additional cover-
18 age for eligible employees and their family members at an additional cost or premium.

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

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

28 (8)(a) The board shall use payment methodologies in self-insured health benefit plans offered by
29 the board that are designed to limit the growth in per-member expenditures for health services to
30 no more than 3.4 percent per year. The assessment paid in accordance with section 3, chapter 538,
31 Oregon Laws 2017, shall be excluded in determining the 3.4 percent annual increase in per-member
32 expenditures for health services.

33 (b) The board shall adopt policies and practices designed to limit the annual increase in pre-
34 mium amounts paid for contracted health benefit plans to 3.4 percent, **including but not limited**
35 **to contracting only with insurers that voluntarily sign a compact or enter into another form**
36 **of agreement with the Oregon Health Authority committing to take steps to achieve a target**
37 **percentage of all payments to providers being made using value-based payment methods in-**
38 **stead of the fee-for-service method.**

39 (9) As frequently as is recommended as a commercial best practice by consultants engaged by
40 the board, the board shall conduct an audit of the health benefit plan enrollees' continued eligibility
41 for coverage as spouses or dependents or any other basis that would affect the cost of the premium
42 for the plan.

43 (10) If the board spends less than 12 percent of its total medical expenditures in self-insured
44 health benefit plans on payments for primary care, the board shall implement a plan for increasing
45 the percentage of total medical expenditures spent on payments for primary care by at least one

1 percent each year.

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

6 **SECTION 3.** ORS 243.866 is amended to read:

7 243.866. (1) The Oregon Educators Benefit Board shall contract for benefit plans best designed
8 to meet the needs and provide for the welfare of eligible employees, the districts and local govern-
9 ments. In considering whether to enter into a contract for a benefit plan, the board shall place em-
10 phasis on:

11 (a) Employee choice among high-quality plans;

12 (b) Encouragement of a competitive marketplace;

13 (c) Plan performance and information;

14 (d) District and local government flexibility in plan design and contracting;

15 (e) Quality customer service;

16 (f) Creativity and innovation;

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

18 (h) Improvement of employee health; and

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

21 (2) The board may approve more than one carrier for each type of benefit plan offered, but the
22 board shall limit the number of carriers to a number consistent with adequate service to eligible
23 employees and family members. The board shall impose a surcharge in an amount determined by the
24 board on an eligible employee who arranges coverage for the employee's spouse or dependent under
25 this subsection if the spouse or dependent has access to medical coverage as an employee in another
26 health benefit plan offered by the board or the Public Employees' Benefit Board.

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

29 (4) A district or a local government shall provide that payroll deductions for benefit plan costs
30 that are not payable by the district or local government may be made upon receipt of a signed au-
31 thorization from the employee indicating an election to participate in the benefit plan or plans se-
32 lected and allowing the deduction of those costs from the employee's pay.

33 (5) In developing any benefit plan, the board may provide an option of additional coverage for
34 eligible employees and family members at an additional premium.

35 (6) The board shall adopt rules providing that transfer of enrollment from one benefit plan to
36 another is open to all eligible employees and family members. Because of the special problems that
37 may arise involving acceptable provider-patient relations between a particular panel of providers
38 and a particular eligible employee or family member under a comprehensive group practice benefit
39 plan, the board shall provide a procedure under which any eligible employee may apply at any time
40 to substitute another benefit plan for participation in a comprehensive group practice benefit plan.

41 (7) An eligible employee who is retired is not required to participate in a health benefit plan
42 offered under this section in order to obtain dental benefit plan coverage. The board shall establish
43 by rule standards of eligibility for retired employees to participate in a dental benefit plan.

44 (8) The board shall evaluate a benefit plan that serves a limited geographic region of this state
45 according to the criteria described in subsection (1) of this section.

1 (9)(a) The board shall use payment methodologies in self-insured health benefit plans offered by
2 the board that are designed to limit the growth in per-member expenditures for health services to
3 no more than 3.4 percent per year, **including but not limited to contracting only with insurers**
4 **that voluntarily sign a compact or enter into another form of agreement with the Oregon**
5 **Health Authority committing to take steps to achieve a target percentage of all payments**
6 **to providers being made using value-based payment methods instead of the fee-for-service**
7 **method.**

8 (b) The board shall adopt policies and practices designed to limit the annual increase in pre-
9 mium amounts paid for contracted health benefit plans to 3.4 percent.

10 (10) As frequently as is recommended as a commercial best practice by consultants engaged by
11 the board, the board shall conduct an audit of the health benefit plan enrollees' continued eligibility
12 for coverage as spouses or dependents or any other basis that would affect the cost of the premium
13 for the plan.

14 (11) By January 1, 2023, the board shall spend at least 12 percent of its total medical expen-
15 ditures in self-insured health benefit plans on payments for primary care.

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

19 **SECTION 4.** ORS 243.866, as amended by section 17, chapter 489, Oregon Laws 2017, and sec-
20 tion 4, chapter 484, Oregon Laws 2019, is amended to read:

21 243.866. (1) The Oregon Educators Benefit Board shall contract for benefit plans best designed
22 to meet the needs and provide for the welfare of eligible employees, the districts and local govern-
23 ments. In considering whether to enter into a contract for a benefit plan, the board shall place em-
24 phasis on:

25 (a) Employee choice among high-quality plans;

26 (b) Encouragement of a competitive marketplace;

27 (c) Plan performance and information;

28 (d) District and local government flexibility in plan design and contracting;

29 (e) Quality customer service;

30 (f) Creativity and innovation;

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

32 (h) Improvement of employee health; and

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

35 (2) The board may approve more than one carrier for each type of benefit plan offered, but the
36 board shall limit the number of carriers to a number consistent with adequate service to eligible
37 employees and family members. The board shall impose a surcharge in an amount determined by the
38 board on an eligible employee who arranges coverage for the employee's spouse or dependent under
39 this subsection if the spouse or dependent has access to medical coverage as an employee in another
40 health benefit plan offered by the board or the Public Employees' Benefit Board.

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

43 (4) A district or a local government shall provide that payroll deductions for benefit plan costs
44 that are not payable by the district or local government may be made upon receipt of a signed au-
45 thorization from the employee indicating an election to participate in the benefit plan or plans se-

1 lected and allowing the deduction of those costs from the employee's pay.

2 (5) In developing any benefit plan, the board may provide an option of additional coverage for
3 eligible employees and family members at an additional premium.

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

10 (7) An eligible employee who is retired is not required to participate in a health benefit plan
11 offered under this section in order to obtain dental benefit plan coverage. The board shall establish
12 by rule standards of eligibility for retired employees to participate in a dental benefit plan.

13 (8) The board shall evaluate a benefit plan that serves a limited geographic region of this state
14 according to the criteria described in subsection (1) of this section.

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

18 (b) The board shall adopt policies and practices designed to limit the annual increase in pre-
19 mium amounts paid for contracted health benefit plans to 3.4 percent, **including but not limited**
20 **to contracting only with insurers that voluntarily sign a compact or enter into another form**
21 **of agreement with the Oregon Health Authority committing to take steps to achieve a target**
22 **percentage of all payments to providers being made using value-based payment methods in-**
23 **stead of the fee-for-service method.**

24 (10) As frequently as is recommended as a commercial best practice by consultants engaged by
25 the board, the board shall conduct an audit of the health benefit plan enrollees' continued eligibility
26 for coverage as spouses or dependents or any other basis that would affect the cost of the premium
27 for the plan.

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

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

36 **SECTION 5.** ORS 414.572 is amended to read:

37 414.572. (1) The Oregon Health Authority shall adopt by rule the qualification criteria and re-
38 quirements for a coordinated care organization and shall integrate the criteria and requirements
39 into each contract with a coordinated care organization. Coordinated care organizations may be
40 local, community-based organizations or statewide organizations with community-based participation
41 in governance or any combination of the two. Coordinated care organizations may contract with
42 counties or with other public or private entities to provide services to members. The authority may
43 not contract with only one statewide organization. A coordinated care organization may be a single
44 corporate structure or a network of providers organized through contractual relationships. The cri-
45 teria and requirements adopted by the authority under this section must include, but are not limited

1 to, a requirement that the coordinated care organization:

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

4 (b) Meet the following minimum financial requirements:

5 (A) Maintain restricted reserves of \$250,000 plus an amount equal to 50 percent of the coordi-
6 nated care organization's total actual or projected liabilities above \$250,000.

7 (B) Maintain capital or surplus of not less than \$2,500,000 and any additional amounts necessary
8 to ensure the solvency of the coordinated care organization, as specified by the authority by rules
9 that are consistent with ORS 731.554 (6), 732.225, 732.230 and 750.045.

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

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

20 (d) Develop and implement alternative payment methodologies that are based on health care
21 quality and improved health outcomes **and sign a voluntary compact or enter into another form**
22 **of agreement with the authority committing to take steps to achieve a target percentage of**
23 **all payments to providers being made using value-based payment methods.**

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

26 (f) Engage community members and health care providers in improving the health of the com-
27 munity and addressing regional, cultural, socioeconomic and racial disparities in health care that
28 exist among the coordinated care organization's members and in the coordinated care organization's
29 community.

30 (2) In addition to the criteria and requirements specified in subsection (1) of this section, the
31 authority must adopt by rule requirements for coordinated care organizations contracting with the
32 authority so that:

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

35 (b) Each member has a consistent and stable relationship with a care team that is responsible
36 for comprehensive care management and service delivery.

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

41 (d) Members receive comprehensive transitional care, including appropriate follow-up, when en-
42 tering and leaving an acute care facility or a long term care setting.

43 (e) Members receive assistance in navigating the health care delivery system and in accessing
44 community and social support services and statewide resources, including through the use of certi-
45 fied health care interpreters and qualified health care interpreters, as those terms are defined in

1 ORS 413.550.

2 (f) Services and supports are geographically located as close to where members reside as possi-
 3 ble and are, if available, offered in nontraditional settings that are accessible to families, diverse
 4 communities and underserved populations.

5 (g) Each coordinated care organization uses health information technology to link services and
 6 care providers across the continuum of care to the greatest extent practicable and if financially vi-
 7 able.

8 (h) Each coordinated care organization complies with the safeguards for members described in
 9 ORS 414.605.

10 (i) Each coordinated care organization convenes a community advisory council that meets the
 11 criteria specified in ORS 414.575.

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

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

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

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

23 (C) Emphasize prevention, healthy lifestyle choices, evidence-based practices, shared decision-
 24 making and communication.

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

26 (E) Include providers of specialty care.

27 (F) Are selected by coordinated care organizations using universal application and credentialing
 28 procedures and objective quality information and are removed if the providers fail to meet objective
 29 quality standards.

30 (G) Work together to develop best practices for culturally appropriate care and service delivery
 31 to reduce waste, reduce health disparities and improve the health and well-being of members.

32 (L) Each coordinated care organization reports on outcome and quality measures adopted under
 33 ORS 414.638 and participates in the health care data reporting system established in ORS 442.372
 34 and 442.373.

35 (m) Each coordinated care organization uses best practices in the management of finances,
 36 contracts, claims processing, payment functions and provider networks.

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

39 (o) Each coordinated care organization has a governing body that complies with ORS 414.584
 40 and that includes:

41 (A) At least one member representing persons that share in the financial risk of the organiza-
 42 tion;

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

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

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

1 (i) A physician licensed under ORS chapter 677 or a nurse practitioner licensed under ORS
2 678.375, whose area of practice is primary care; and

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

4 (E) At least two members from the community at large, to ensure that the organization's
5 decision-making is consistent with the values of the members and the community; and

6 (F) At least two members of the community advisory council, one of whom is or was within the
7 previous six months a recipient of medical assistance and is at least 16 years of age, or a parent,
8 guardian or primary caregiver of an individual who is or was within the previous six months a re-
9 cipient of medical assistance.

10 (p) Each coordinated care organization's governing body establishes standards for publicizing
11 the activities of the coordinated care organization and the organization's community advisory
12 councils, as necessary, to keep the community informed.

13 (q) Each coordinated care organization publishes on a website maintained by or on behalf of the
14 coordinated care organization, in a manner determined by the authority, a document designed to
15 educate members about best practices, care quality expectations, screening practices, treatment
16 options and other support resources available for members who have mental illnesses or substance
17 use disorders.

18 (r) Each coordinated care organization works with the Tribal Advisory Council established in
19 ORS 414.581 and has a dedicated tribal liaison, selected by the council, to:

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

23 (B) Participate in the community health assessment and the development of the health im-
24 provement plan;

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

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

30 (3) The authority shall consider the participation of area agencies and other nonprofit agencies
31 in the configuration of coordinated care organizations.

32 (4) In selecting one or more coordinated care organizations to serve a geographic area, the au-
33 thority shall:

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

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

36 (c) Allow more than one coordinated care organization to serve the geographic area if necessary
37 to optimize access and choice under this subsection.

38 (5) On or before July 1, 2014, each coordinated care organization must have a formal contractual
39 relationship with any dental care organization that serves members of the coordinated care organ-
40 ization in the area where they reside.

41 **SECTION 6.** ORS 414.572, as amended by section 14, chapter 489, Oregon Laws 2017, section
42 4, chapter 49, Oregon Laws 2018, section 8, chapter 358, Oregon Laws 2019, section 2, chapter 364,
43 Oregon Laws 2019, section 58, chapter 478, Oregon Laws 2019, and section 7, chapter 529, Oregon
44 Laws 2019, is amended to read:

45 414.572. (1) The Oregon Health Authority shall adopt by rule the qualification criteria and re-

1 requirements for a coordinated care organization and shall integrate the criteria and requirements
2 into each contract with a coordinated care organization. Coordinated care organizations may be
3 local, community-based organizations or statewide organizations with community-based participation
4 in governance or any combination of the two. Coordinated care organizations may contract with
5 counties or with other public or private entities to provide services to members. The authority may
6 not contract with only one statewide organization. A coordinated care organization may be a single
7 corporate structure or a network of providers organized through contractual relationships. The cri-
8 teria and requirements adopted by the authority under this section must include, but are not limited
9 to, a requirement that the coordinated care organization:

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

12 (b) Meet the following minimum financial requirements:

13 (A) Maintain restricted reserves of \$250,000 plus an amount equal to 50 percent of the coordi-
14 nated care organization's total actual or projected liabilities above \$250,000.

15 (B) Maintain capital or surplus of not less than \$2,500,000 and any additional amounts necessary
16 to ensure the solvency of the coordinated care organization, as specified by the authority by rules
17 that are consistent with ORS 731.554 (6), 732.225, 732.230 and 750.045.

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

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

28 (d) Develop and implement alternative payment methodologies that are based on health care
29 quality and improved health outcomes **and sign a voluntary compact or enter into another form**
30 **of agreement with the authority committing to take steps to achieve a target percentage of**
31 **all payments to providers being made using value-based payment methods.**

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

34 (f) Engage community members and health care providers in improving the health of the com-
35 munity and addressing regional, cultural, socioeconomic and racial disparities in health care that
36 exist among the coordinated care organization's members and in the coordinated care organization's
37 community.

38 (2) In addition to the criteria and requirements specified in subsection (1) of this section, the
39 authority must adopt by rule requirements for coordinated care organizations contracting with the
40 authority so that:

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

43 (b) Each member has a consistent and stable relationship with a care team that is responsible
44 for comprehensive care management and service delivery.

45 (c) The supportive and therapeutic needs of each member are addressed in a holistic fashion,

1 using patient centered primary care homes, behavioral health homes or other models that support
2 patient centered primary care and behavioral health care and individualized care plans to the extent
3 feasible.

4 (d) Members receive comprehensive transitional care, including appropriate follow-up, when en-
5 tering and leaving an acute care facility or a long term care setting.

6 (e) Members receive assistance in navigating the health care delivery system and in accessing
7 community and social support services and statewide resources, including through the use of certi-
8 fied health care interpreters and qualified health care interpreters, as those terms are defined in
9 ORS 413.550.

10 (f) Services and supports are geographically located as close to where members reside as possi-
11 ble and are, if available, offered in nontraditional settings that are accessible to families, diverse
12 communities and underserved populations.

13 (g) Each coordinated care organization uses health information technology to link services and
14 care providers across the continuum of care to the greatest extent practicable and if financially vi-
15 able.

16 (h) Each coordinated care organization complies with the safeguards for members described in
17 ORS 414.605.

18 (i) Each coordinated care organization convenes a community advisory council that meets the
19 criteria specified in ORS 414.575.

20 (j) Each coordinated care organization prioritizes working with members who have high health
21 care needs, multiple chronic conditions, mental illness or chemical dependency and involves those
22 members in accessing and managing appropriate preventive, health, remedial and supportive care
23 and services, including the services described in ORS 414.766, to reduce the use of avoidable emer-
24 gency room visits and hospital admissions.

25 (k) Members have a choice of providers within the coordinated care organization's network and
26 that providers participating in a coordinated care organization:

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

29 (B) Are educated about the integrated approach and how to access and communicate within the
30 integrated system about a patient's treatment plan and health history.

31 (C) Emphasize prevention, healthy lifestyle choices, evidence-based practices, shared decision-
32 making and communication.

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

34 (E) Include providers of specialty care.

35 (F) Are selected by coordinated care organizations using universal application and credentialing
36 procedures and objective quality information and are removed if the providers fail to meet objective
37 quality standards.

38 (G) Work together to develop best practices for culturally appropriate care and service delivery
39 to reduce waste, reduce health disparities and improve the health and well-being of members.

40 (L) Each coordinated care organization reports on outcome and quality measures adopted under
41 ORS 414.638 and participates in the health care data reporting system established in ORS 442.372
42 and 442.373.

43 (m) Each coordinated care organization uses best practices in the management of finances,
44 contracts, claims processing, payment functions and provider networks.

45 (n) Each coordinated care organization participates in the learning collaborative described in

1 ORS 413.259 (3).

2 (o) Each coordinated care organization has a governing body that complies with ORS 414.584
3 and that includes:

4 (A) At least one member representing persons that share in the financial risk of the organiza-
5 tion;

6 (B) A representative of a dental care organization selected by the coordinated 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 licensed under ORS
10 678.375, 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 the organization's
13 decision-making is consistent with the values of the members and the community; and

14 (F) At least two members of the community advisory council, one of whom is or was within the
15 previous six months a recipient of medical assistance and is at least 16 years of age or a parent,
16 guardian or primary caregiver of an individual who is or was within the previous six months a re-
17 cipient of medical assistance.

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

21 (q) Each coordinated care organization publishes on a website maintained by or on behalf of the
22 coordinated care organization, in a manner determined by the authority, a document designed to
23 educate members about best practices, care quality expectations, screening practices, treatment
24 options and other support resources available for members who have mental illnesses or substance
25 use disorders.

26 (r) Each coordinated care organization works with the Tribal Advisory Council established in
27 ORS 414.581 and has a dedicated tribal liaison, selected by the council, to:

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

31 (B) Participate in the community health assessment and the development of the health im-
32 provement plan;

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

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

38 (3) The authority shall consider the participation of area agencies and other nonprofit agencies
39 in the configuration of coordinated care organizations.

40 (4) In selecting one or more coordinated care organizations to serve a geographic area, the au-
41 thority shall:

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

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

44 (c) Allow more than one coordinated care organization to serve the geographic area if necessary
45 to optimize access and choice under this subsection.

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

4
