Enrolled
House Bill 3353

Sponsored by Representatives RAYFIELD, LEIF, WILLIAMS, Senator ANDERSON; Representatives ALONSO LEON, CAMPOS, DEXTER, FAHEY, LEVY, MARSH, MEEK, MOORE-GREEN, MORGAN, NOBLE, POWER, REYNOLDS, SALINAS, SANCHEZ, SCHOUTEN, SMITH G, STARK, WILDE, Senators FREDERICK, KENNEMER, LIEBER, PATTERSON

CHAPTER .....

AN ACT

Relating to health care expenditures; and prescribing an effective date.

Whereas addressing health inequities is critical to achieving health equity in this state; and

Whereas health equity means all people can reach their full health potential and well-being and are not disadvantaged by their race, ethnicity, language, disability, gender, gender identity, sexual orientation, social class, intersections among these communities or identities or other socially determined circumstances; and

Whereas increasing access to mental health care is vitally important to achieving the health goals of this state; and

Whereas achieving health equity requires the ongoing collaboration of all regions and sections of this state, including tribal governments, to address the equitable distribution or redistribution of resources and power and to recognize, reconcile and rectify historical and contemporary injustices; now, therefore,

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

SECTION 1. Section 2 of this 2021 Act is added to and made a part of ORS chapter 414.

SECTION 2. (1) As used in this section, "health equity" has the meaning prescribed by the Oregon Health Policy Board and adopted by the Oregon Health Authority by rule.

(2) The authority shall seek approval from the Centers for Medicare and Medicaid Services to:

(a) Require a coordinated care organization to spend up to three percent of its global budget on investments:

(A)(i) In programs or services that improve health equity by addressing the preventable differences in the burden of disease, injury or violence or in opportunities to achieve optimal health that are experienced by socially disadvantaged populations;

(ii) In community-based programs addressing the social determinants of health;

(iii) In efforts to diversify care locations; or

(iv) In programs or services that improve the overall health of the community; or

(B) That enhance payments to:

(i) Providers who address the need for culturally and linguistically appropriate services in their communities;

(ii) Providers who can demonstrate that increased funding will improve health services provided to the community as a whole; or

(iii) Support staff based in the community that aid all underserved populations, including but not limited to peer-to-peer support staff with cultural backgrounds, health system navigators in nonmedical settings and public guardians.

(b) Require a coordinated care organization to spend at least 30 percent of the funds described in paragraph (a) of this subsection on programs or efforts to achieve health equity for racial, cultural or traditionally underserved populations in the communities served by the coordinated care organization.

(c) Require a coordinated care organization to spend at least 20 percent of the funds described in paragraph (a) of this subsection on efforts to:

(A) Improve the behavioral health of members;

(B) Improve the behavioral health care delivery system in the community served by the coordinated care organization;

(C) Create a culturally and linguistically competent health care workforce; or

(D) Improve the behavioral health of the community as a whole.

(3) Expenditures described in subsection (2) of this section are in addition to the expenditures required by ORS 414.572 (1)(b)(C) and must:

(a) Be part of a plan developed in collaboration with or directed by members of organizations or organizations that serve local priority populations that are underserved in communities served by the coordinated care organization, including but not limited to regional health equity coalitions, and be approved by the coordinated care organization's community advisory council;

(b) Demonstrate, through practice-based or community-based evidence, improved health outcomes for individual members of the coordinated care organization or the overall community served by the coordinated care organization;

(c) Be expended from a coordinated care organization's global budget with the least amount of state funding; and

(d) Be counted as medical expenses by the authority in a coordinated care organization's base medical budget when calculating the coordinated care organization's global budget and flexible spending requirements for a given year.

(4) Expenditures by a coordinated care organization in working with one or more of the nine federally recognized tribes in this state or urban Indian health programs to achieve health equity may qualify as expenditures under subsection (2) of this section.

(5) The authority shall:

(a) Make publicly available the outcomes described in subsection (3)(b) of this section; and

(b) Report expenditures under subsection (2) of this section to the Centers for Medicare and Medicaid Services.

(6) Upon receipt of approval from the Centers for Medicare and Medicaid Services to carry out the provisions of this section, the authority shall adopt rules in accordance with the terms of the approval.

SECTION 3. Section 2 of this 2021 Act is amended to read:

Sec. 2. (1) As used in this section, "health equity" has the meaning prescribed by the Oregon Health Policy Board and adopted by the Oregon Health Authority by rule.

(2) The authority shall [*seek approval from the Centers for Medicare and Medicaid Services to*]:

(a) Require a coordinated care organization to spend [*up to*] **no less than** three percent of its global budget on investments:

(A)(i) In programs or services that improve health equity by addressing the preventable differences in the burden of disease, injury or violence or in opportunities to achieve optimal health that are experienced by socially disadvantaged populations;

(ii) In community-based programs addressing the social determinants of health;

(iii) In efforts to diversify care locations; or

(iv) In programs or services that improve the overall health of the community; or

(B) That enhance payments to:

(i) Providers who address the need for culturally and linguistically appropriate services in their communities;

(ii) Providers who can demonstrate that increased funding will improve health services provided to the community as a whole; or

(iii) Support staff based in the community that aid all underserved populations, including but not limited to peer-to-peer support staff with cultural backgrounds, health system navigators in nonmedical settings and public guardians.

(b) Require a coordinated care organization to spend at least 30 percent of the funds described in paragraph (a) of this subsection on programs or efforts to achieve health equity for racial, cultural or traditionally underserved populations in the communities served by the coordinated care organization.

(c) Require a coordinated care organization to spend at least 20 percent of the funds described in paragraph (a) of this subsection on efforts to:

(A) Improve the behavioral health of members;

(B) Improve the behavioral health care delivery system in the community served by the coordinated care organization;

(C) Create a culturally and linguistically competent health care workforce; or

(D) Improve the behavioral health of the community as a whole.

(3) Expenditures described in subsection (2) of this section are in addition to the expenditures required by ORS 414.572 (1)(b)(C) and must:

(a) Be part of a plan developed in collaboration with or directed by members of organizations or organizations that serve local priority populations that are underserved in communities served by the coordinated care organization, including but not limited to regional health equity coalitions, and be approved by the coordinated care organization's community advisory council;

(b) Demonstrate, through practice-based or community-based evidence, improved health outcomes for individual members of the coordinated care organization or the overall community served by the coordinated care organization;

(c) Be expended from a coordinated care organization's global budget with the least amount of state funding; and

(d) Be counted as medical expenses by the authority in a coordinated care organization's base medical budget when calculating the coordinated care organization's global budget and flexible spending requirements for a given year.

(4) Expenditures by a coordinated care organization in working with one or more of the nine federally recognized tribes in this state or urban Indian health programs to achieve health equity may qualify as expenditures under subsection (2) of this section.

(5) The authority shall:

(a) Make publicly available the outcomes described in subsection (3)(b) of this section; and

(b) Report expenditures under subsection (2) of this section to the Centers for Medicare and Medicaid Services.

[*(6) Upon receipt of approval from the Centers for Medicare and Medicaid Services to carry out the provisions of this section, the authority shall adopt rules in accordance with the terms of the approval.*]

(6) The authority shall convene an oversight committee in consultation with the office within the authority that is charged with ensuring equity and inclusion. The oversight committee shall be composed of members who represent the regional and demographic diversity of this state based on statistical evidence compiled by the authority about medical assistance recipients and at least one representative from the nine federally recognized tribes in this state or urban Indian health programs. The oversight committee shall:

(a) Evaluate the impact of expenditures described in subsection (2) of this section on promoting health equity and improving the social determinants of health in the communities served by each coordinated care organization;

(b) Recommend best practices and criteria for investments described in subsection (2) of this section; and

(c) Resolve any disputes between the authority and a coordinated care organization over what qualifies as an expenditure under subsection (2) of this section.

SECTION 4. (1) The amendments to section 2 of this 2021 Act by section 3 of this 2021 Act become operative upon receipt of approval from the Centers for Medicare and Medicaid Services to carry out section 2 of this 2021 Act as described in section 2 (2) and (3)(c) of this 2021 Act.

(2) The Director of the Oregon Health Authority shall notify the Legislative Counsel immediately upon receipt of an approval or denial by the Centers for Medicare and Medicaid Services to carry out section 2 of this 2021 Act.

SECTION 5. This 2021 Act takes effect on the 91st day after the date on which the 2021 regular session of the Eighty-first Legislative Assembly adjourns sine die.

Passed by House June 17, 2021

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Timothy G. Sekerak, Chief Clerk of House

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Tina Kotek, Speaker of House

Passed by Senate June 23, 2021

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Peter Courtney, President of Senate

Received by Governor:

.....M.,....., 2021

Approved:

.....M.,....., 2021

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Kate Brown, Governor

Filed in Office of Secretary of State:

.....M.,....., 2021

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Shemia Fagan, Secretary of State