

D R A F T

SUMMARY

Allows Oregon Health Authority to reimburse coordinated care organizations using payment mechanisms other than global budgets under specified circumstances.

Replaces Health Plan Quality Metrics Committee and metrics and scoring subcommittee with Health Equity Quality Metrics Committee and modifies duties and functions. Authorizes specified incentives for compliance with quality measures adopted by committee.

Eliminates requirement that initial health assessments by coordinated care organizations on children in foster care be performed in accordance with quality metrics established by metrics and scoring subcommittee.

Deletes obsolete references to prepaid managed care health services organizations and dental care organizations.

Declares emergency, effective on passage.

A BILL FOR AN ACT

1
2 Relating to health care; creating new provisions; amending ORS 192.395,
3 192.579, 243.135, 243.866, 413.011, 413.017, 413.032, 413.181, 413.550, 414.025,
4 414.430, 414.570, 414.572, 414.591, 414.607, 414.619, 414.631, 414.686, 414.764,
5 414.880, 414.882, 414.884, 414.902, 415.500, 416.510, 416.540, 417.721, 646.639,
6 679.540, 741.300, 743.029 and 743B.470 and section 2, chapter 575, Oregon
7 Laws 2015, section 1, chapter 61, Oregon Laws 2022, and section 1, chapter
8 87, Oregon Laws 2022; repealing ORS 414.638 and 414.654; and declaring
9 an emergency.

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

REIMBURSEMENT FOR SERVICES PROVIDED

BY COORDINATED CARE ORGANIZATIONS

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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 **SECTION 1.** ORS 414.572, as amended by section 14, chapter 489, Oregon
2 Laws 2017, section 4, chapter 49, Oregon Laws 2018, section 8, chapter 358,
3 Oregon Laws 2019, section 2, chapter 364, Oregon Laws 2019, section 58,
4 chapter 478, Oregon Laws 2019, section 7, chapter 529, Oregon Laws 2019, and
5 section 14, chapter 453, Oregon Laws 2021, is amended to read:

6 414.572. (1) The Oregon Health Authority shall adopt by rule the quali-
7 fication criteria and requirements for a coordinated care organization and
8 shall integrate the criteria and requirements into each contract with a co-
9 ordinated care organization. Coordinated care organizations may be local,
10 community-based organizations or statewide organizations with community-
11 based participation in governance or any combination of the two. Coordi-
12 nated care organizations may contract with counties or with other public or
13 private entities to provide services to members. The authority may not
14 contract with only one statewide organization. A coordinated care organiza-
15 tion may be a single corporate structure or a network of providers organized
16 through contractual relationships. The criteria and requirements adopted by
17 the authority under this section must include, but are not limited to, a re-
18 quirement that the coordinated care organization:

19 (a) Have demonstrated experience and a capacity for managing financial
20 risk and establishing financial reserves.

21 (b) Meet the following minimum financial requirements:

22 (A) Maintain restricted reserves of \$250,000 plus an amount equal to 50
23 percent of the coordinated care organization's total actual or projected li-
24 abilities above \$250,000.

25 (B) Maintain capital or surplus of not less than \$2,500,000 and any addi-
26 tional amounts necessary to ensure the solvency of the coordinated care or-
27 ganization, as specified by the authority by rules that are consistent with
28 ORS 731.554 (6), 732.225, 732.230 and 750.045.

29 (C) Expend a portion of the annual net income or reserves of the coordi-
30 nated care organization that exceed the financial requirements specified in
31 this paragraph on services designed to address health disparities and the

1 social determinants of health consistent with the coordinated care
2 organization's community health improvement plan and transformation plan
3 and the terms and conditions of the Medicaid demonstration project under
4 section 1115 of the Social Security Act (42 U.S.C. 1315).

5 (c) Operate within a fixed global budget **and other payment mech-**
6 **anisms described in subsection (6) of this section** and spend on primary
7 care, as defined by the authority by rule, at least 12 percent of the coordi-
8 nated care organization's total expenditures for physical and mental health
9 care provided to members, except for expenditures on prescription drugs, vi-
10 sion care and dental care.

11 (d) Develop and implement alternative payment methodologies that are
12 based on health care quality and improved health outcomes.

13 (e) Coordinate the delivery of physical health care, behavioral health
14 care, oral health care and covered long-term care services.

15 (f) Engage community members and health care providers in improving
16 the health of the community and addressing regional, cultural, socioeconomic
17 and racial disparities in health care that exist among the coordinated care
18 organization's members and in the coordinated care organization's commu-
19 nity.

20 (2) In addition to the criteria and requirements specified in subsection (1)
21 of this section, the authority must adopt by rule requirements for coordi-
22 nated care organizations contracting with the authority so that:

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

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

29 (c) The supportive and therapeutic needs of each member are addressed
30 in a holistic fashion, using patient centered primary care homes, behavioral
31 health homes or other models that support patient centered primary care and

1 behavioral health care and individualized care plans to the extent feasible.

2 (d) Members receive comprehensive transitional care, including appropri-
3 ate follow-up, when entering and leaving an acute care facility or a long
4 term care setting.

5 (e) Members are provided:

6 (A) Assistance in navigating the health care delivery system;

7 (B) Assistance in accessing community and social support services and
8 statewide resources;

9 (C) Meaningful language access as required by federal and state law in-
10 cluding, but not limited to, 42 U.S.C. 18116, Title VI of the Civil Rights Act
11 of 1964, Title VI Guidance issued by the United States Department of Justice
12 and the National Standards for Culturally and Linguistically Appropriate
13 Services in Health and Health Care as issued by the United States Depart-
14 ment of Health and Human Services; and

15 (D) Qualified health care interpreters or certified health care interpreters
16 listed on the health care interpreter registry, as those terms are defined in
17 ORS 413.550.

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

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

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

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

29 (j) Each coordinated care organization prioritizes working with members
30 who have high health care needs, multiple chronic conditions or behavioral
31 health conditions and involves those members in accessing and managing

1 appropriate preventive, health, remedial and supportive care and services,
2 including the services described in ORS 414.766, to reduce the use of avoid-
3 able 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 prac-
13 tices, 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 appli-
18 cation 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 and linguis-
21 tically appropriate care and service delivery to reduce waste, reduce health
22 disparities and improve 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*] **established under ORS 413.017 (4)**
25 and participates in the health care data reporting system established in ORS
26 442.372 and 442.373.

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

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

1 (o) Each coordinated care organization has a governing body that com-
2 plies with ORS 414.584 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 coordi-
6 nated care organization;]*

7 *[(C)] (B)* The major components of the health care delivery system;

8 *[(D)] (C)* At least two health care providers in active practice, including:

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

11 (ii) A behavioral health provider;

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

15 *[(F)] (E)* At least two members of the community advisory council, one
16 of whom is or was within the previous six months a recipient of medical
17 assistance and is at least 16 years of age or a parent, guardian or primary
18 caregiver of an individual who is or was within the previous six months a
19 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 publishes on a website maintained
25 by or on behalf of the coordinated care organization, in a manner determined
26 by the authority, a document designed to educate members about best prac-
27 tices, care quality expectations, screening practices, treatment options and
28 other support resources available for members who have mental illnesses or
29 substance use disorders.

30 (r) Each coordinated care organization works with the Tribal Advisory
31 Council established in ORS 414.581 and has a dedicated tribal liaison, se-

1 lected by the council, to:

2 (A) Facilitate a resolution of any issues that arise between the coordi-
3 nated care organization and a provider of Indian health services within the
4 area served by the coordinated care organization;

5 (B) Participate in the community health assessment and the development
6 of the health improvement plan;

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

8 (D) Be available for training by the office within the authority that is
9 responsible for tribal affairs, any federally recognized tribe in Oregon and
10 the urban Indian health program that is located within the area served by
11 the coordinated care organization and operated by an urban Indian organ-
12 ization pursuant to 25 U.S.C. 1651.

13 (3) The authority shall consider the participation of area agencies and
14 other nonprofit agencies in the configuration of coordinated care organiza-
15 tions.

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

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

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

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

25 *[(5) On or before July 1, 2014, each coordinated care organization must have*
26 *a formal contractual relationship with any dental care organization that serves*
27 *members of the coordinated care organization in the area where they reside.]*

28 **(5) In addition to global budgets, the authority may employ other**
29 **payment mechanisms to reimburse coordinated care organizations for**
30 **specified health services during limited periods of time if:**

31 **(a) Global budgets remain the predominant means of reimbursing**

1 **coordinated care organizations for care and services provided to the**
2 **coordinated care organization’s members; and**

3 **(b) The other payment mechanisms are consistent with the legisla-**
4 **tive intent expressed in ORS 414.018 and the system design described**
5 **in ORS 414.570 (1).**

6 **SECTION 2.** ORS 414.570 is amended to read:

7 414.570. (1) There is established the Oregon Integrated and Coordinated
8 Health Care Delivery System. The system shall consist of state policies and
9 actions that make coordinated care organizations accountable for care man-
10 agement and provision of integrated and coordinated health care for each
11 organization’s members[, *managed within fixed global budgets,*] by providing
12 care so that efficiency and quality improvements reduce medical cost in-
13 flation while supporting the development of regional and community ac-
14 countability for the health of the residents of each region and community,
15 and while maintaining regulatory controls necessary to ensure quality and
16 affordable health care for all Oregonians.

17 (2) The Oregon Health Authority shall seek input from groups and indi-
18 viduals who are part of underserved communities, including ethnically di-
19 verse populations, geographically isolated groups, seniors, people with
20 disabilities and people using mental health services, and shall also seek input
21 from providers, coordinated care organizations and communities, in the de-
22 velopment of strategies that promote person centered care and encourage
23 healthy behaviors, healthy lifestyles and prevention and wellness activities
24 and promote the development of patients’ skills in self-management and ill-
25 ness management.

26 (3) The authority shall regularly report to the Oregon Health Policy
27 Board, the Governor and the Legislative Assembly on the progress of pay-
28 ment reform and delivery system change including:

- 29 (a) The achievement of benchmarks;
- 30 (b) Progress toward eliminating health disparities;
- 31 (c) Results of evaluations;

- 1 (d) Rules adopted;
- 2 (e) Customer satisfaction;
- 3 (f) Use of patient centered primary care homes and behavioral health
- 4 homes;
- 5 (g) The involvement of local governments in governance and service de-
- 6 livery; and
- 7 (h) Other developments with respect to coordinated care organizations.

8
9 **QUALITY MEASURES**

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11 **SECTION 3.** ORS 413.017 is amended to read:

12 413.017. (1) The Oregon Health Policy Board shall establish the commit-

13 tees described in subsections (2) to (5) of this section.

14 (2)(a) The Public Health Benefit Purchasers Committee shall include in-

15 dividuals who purchase health care for the following:

16 (A) The Public Employees' Benefit Board.

17 (B) The Oregon Educators Benefit Board.

18 (C) Trustees of the Public Employees Retirement System.

19 (D) A city government.

20 (E) A county government.

21 (F) A special district.

22 (G) Any private nonprofit organization that receives the majority of its

23 funding from the state and requests to participate on the committee.

24 (b) The Public Health Benefit Purchasers Committee shall:

25 (A) Identify and make specific recommendations to achieve uniformity

26 across all public health benefit plan designs based on the best available

27 clinical evidence, recognized best practices for health promotion and disease

28 management, demonstrated cost-effectiveness and shared demographics

29 among the enrollees within the pools covered by the benefit plans.

30 (B) Develop an action plan for ongoing collaboration to implement the

31 benefit design alignment described in subparagraph (A) of this paragraph and

1 shall leverage purchasing to achieve benefit uniformity if practicable.

2 (C) Continuously review and report to the Oregon Health Policy Board
3 on the committee's progress in aligning benefits while minimizing the cost
4 shift to individual purchasers of insurance without shifting costs to the pri-
5 vate sector or the health insurance exchange.

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

14 (3)(a) The Health Care Workforce Committee shall include individuals
15 who have the collective expertise, knowledge and experience in a broad
16 range of health professions, health care education and health care workforce
17 development initiatives.

18 (b) The Health Care Workforce Committee shall coordinate efforts to re-
19 cruit and educate health care professionals and retain a quality workforce
20 to meet the demand that will be created by the expansion in health care
21 coverage, system transformations and an increasingly diverse population.

22 (c) The Health Care Workforce Committee shall conduct an inventory of
23 all grants and other state resources available for addressing the need to ex-
24 pand the health care workforce to meet the needs of Oregonians for health
25 care.

26 [(4)(a) *The Health Plan Quality Metrics Committee shall include the fol-*
27 *lowing members appointed by the Oregon Health Policy Board:]*

28 [(A) *An individual representing the Oregon Health Authority;]*

29 [(B) *An individual representing the Oregon Educators Benefit Board;]*

30 [(C) *An individual representing the Public Employees' Benefit Board;]*

31 [(D) *An individual representing the Department of Consumer and Business*

1 *Services;]*

2 *[(E) Two health care providers;]*

3 *[(F) One individual representing hospitals;]*

4 *[(G) One individual representing insurers, large employers or multiple em-*
5 *ployer welfare arrangements;]*

6 *[(H) Two individuals representing health care consumers;]*

7 *[(I) Two individuals representing coordinated care organizations;]*

8 *[(J) One individual with expertise in health care research;]*

9 *[(K) One individual with expertise in health care quality measures; and]*

10 *[(L) One individual with expertise in mental health and addiction*
11 *services.]*

12 *[(b) The committee shall work collaboratively with the Oregon Educators*
13 *Benefit Board, the Public Employees' Benefit Board, the authority and the*
14 *department to adopt health outcome and quality measures that are focused on*
15 *specific goals and provide value to the state, employers, insurers, health care*
16 *providers and consumers. The committee shall be the single body to align*
17 *health outcome and quality measures used in this state with the requirements*
18 *of health care data reporting to ensure that the measures and requirements are*
19 *coordinated, evidence-based and focused on a long term statewide vision.]*

20 *[(c) The committee shall use a public process that includes an opportunity*
21 *for public comment to identify health outcome and quality measures that may*
22 *be applied to services provided by coordinated care organizations or paid for*
23 *by health benefit plans sold through the health insurance exchange or offered*
24 *by the Oregon Educators Benefit Board or the Public Employees' Benefit*
25 *Board. The authority, the department, the Oregon Educators Benefit Board*
26 *and the Public Employees' Benefit Board are not required to adopt all of the*
27 *health outcome and quality measures identified by the committee but may not*
28 *adopt any health outcome and quality measures that are different from the*
29 *measures identified by the committee. The measures must take into account the*
30 *recommendations of the metrics and scoring subcommittee created in ORS*
31 *414.638 and the differences in the populations served by coordinated care or-*

1 *ganizations and by commercial insurers.]*

2 *[(d) In identifying health outcome and quality measures, the committee*
3 *shall prioritize measures that:]*

4 *[(A) Utilize existing state and national health outcome and quality meas-*
5 *ures, including measures adopted by the Centers for Medicare and Medicaid*
6 *Services, that have been adopted or endorsed by other state or national or-*
7 *ganizations and have a relevant state or national benchmark;]*

8 *[(B) Given the context in which each measure is applied, are not prone to*
9 *random variations based on the size of the denominator;]*

10 *[(C) Utilize existing data systems, to the extent practicable, for reporting*
11 *the measures to minimize redundant reporting and undue burden on the state,*
12 *health benefit plans and health care providers;]*

13 *[(D) Can be meaningfully adopted for a minimum of three years;]*

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

16 *[(F) Can be reported in a timely manner and without significant delay so*
17 *that the most current and actionable data is available.]*

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

20 *[(f) The committee may convene subcommittees to focus on gaining expertise*
21 *in particular areas such as data collection, health care research and mental*
22 *health and substance use disorders in order to aid the committee in the de-*
23 *velopment of health outcome and quality measures. A subcommittee may in-*
24 *clude stakeholders and staff from the authority, the Department of Human*
25 *Services, the Department of Consumer and Business Services, the Early*
26 *Learning Council or any other agency staff with the appropriate expertise in*
27 *the issues addressed by the subcommittee.]*

28 *[(g) This subsection does not prevent the authority, the Department of*
29 *Consumer and Business Services, commercial insurers, the Public Employees'*
30 *Benefit Board or the Oregon Educators Benefit Board from establishing pro-*
31 *grams that provide financial incentives to providers for meeting specific health*

1 *outcome and quality measures adopted by the committee.]*

2 **(4)(a) The Health Equity Quality Metrics Committee shall have at**
3 **least 13 members appointed by the Director of the Oregon Health Au-**
4 **thority as follows:**

5 **(A) At least eight members who:**

6 **(i) Represent the interests of groups most affected by health ineq-**
7 **uities, including individuals enrolled in the medical assistance pro-**
8 **gram; or**

9 **(ii) Are health equity researchers or professionals;**

10 **(B) Four members who represent coordinated care organizations**
11 **and health care providers; and**

12 **(C) One member from the Behavioral Health Committee established**
13 **in this section.**

14 **(b) The Health Equity Quality Metrics Committee shall establish**
15 **quality measures and a process for developing quality measures con-**
16 **sistent with the:**

17 **(A) Terms and conditions of the demonstration project approved for**
18 **this state by the Centers for Medicare and Medicaid Services under 42**
19 **U.S.C. 1315; and**

20 **(B) Written quality strategies approved by the Centers for Medicare**
21 **and Medicaid Services under 42 C.F.R. 438.340 and 457.1240.**

22 **(c) The Oregon Health Authority shall evaluate on a regular and**
23 **ongoing basis the quality measures established by the Health Equity**
24 **Quality Metrics Committee under this subsection for members of co-**
25 **ordinated care organizations.**

26 **(5)(a) The Behavioral Health Committee shall include the following**
27 **members appointed by the Director of the Oregon Health Authority:**

28 **[(A) *The chairperson of the Health Plan Quality Metrics Committee;*]**

29 **[(B)] (A) The chairperson of the committee appointed by the board to**
30 **address health equity, if any;**

31 **[(C)] (B) A behavioral health director for a coordinated care organization;**

- 1 [(D)] (C) A representative of a community mental health program;
- 2 [(E)] (D) An individual with expertise in data analysis;
- 3 [(F)] (E) A member of the Consumer Advisory Council, established under
4 ORS 430.073, that represents adults with mental illness;
- 5 [(G)] (F) A representative of the System of Care Advisory Council estab-
6 lished in ORS 418.978;
- 7 [(H)] (G) A member of the Oversight and Accountability Council, de-
8 scribed in ORS 430.389, who represents adults with addictions or co-occurring
9 conditions;
- 10 [(I)] (H) One member representing a system of care, as defined in ORS
11 418.976;
- 12 [(J)] (I) One consumer representative;
- 13 [(K)] (J) One representative of a tribal government;
- 14 [(L)] (K) One representative of an organization that advocates on behalf
15 of individuals with intellectual or developmental disabilities;
- 16 [(M)] (L) One representative of providers of behavioral health services;
- 17 [(N)] (M) The director of the division of the authority responsible for
18 behavioral health services, as a nonvoting member;
- 19 [(O)] (N) The Director of the Alcohol and Drug Policy Commission ap-
20 pointed under ORS 430.220, as a nonvoting member;
- 21 [(P)] (O) The authority's Medicaid director, as a nonvoting member;
- 22 [(Q)] (P) A representative of the Department of Human Services, as a
23 nonvoting member; and
- 24 [(R)] (Q) Any other member that the director deems appropriate.
- 25 (b) The board may modify the membership of the committee as needed.
- 26 (c) The division of the authority responsible for behavioral health services
27 and the director of the division shall staff the committee.
- 28 (d) The committee[, *in collaboration with the Health Plan Quality Metrics*
29 *Committee, as needed,*] shall:
- 30 (A) Establish quality metrics for behavioral health services provided by
31 coordinated care organizations, health care providers, counties and other

1 government entities; and

2 (B) Establish incentives to improve the quality of behavioral health ser-
3 vices.

4 (e) The quality metrics and incentives shall be designed to:

5 (A) Improve timely access to behavioral health care;

6 (B) Reduce hospitalizations;

7 (C) Reduce overdoses;

8 (D) Improve the integration of physical and behavioral health care; and

9 (E) Ensure individuals are supported in the least restrictive environment
10 that meets their behavioral health needs.

11 (6) Members of the committees described in subsections (2) to (5) of this
12 section who are not members of the Oregon Health Policy Board [*are not*
13 *entitled to*] **may receive** compensation [*but*] **in accordance with criteria**
14 **prescribed by the authority by rule and** shall be reimbursed from funds
15 available to the board for actual and necessary travel and other expenses
16 incurred by them by their attendance at committee meetings, in the manner
17 and amount provided in ORS 292.495.

18 **SECTION 4.** ORS 413.032, as amended by section 3, chapter 87, Oregon
19 Laws 2022, is amended to read:

20 413.032. (1) The Oregon Health Authority is established. The authority
21 shall:

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

23 (b) Administer the Oregon Integrated and Coordinated Health Care De-
24 livery System established in ORS 414.570, the COFA Premium Assistance
25 Program established in ORS 413.610 and the COFA Dental Program estab-
26 lished in section 1, chapter 87, Oregon Laws 2022;

27 (c) Administer the Oregon Prescription Drug Program;

28 (d) Develop the policies for and the provision of publicly funded medical
29 care and medical assistance in this state;

30 (e) Develop the policies for and the provision of mental health treatment
31 and treatment of addictions;

1 (f) Assess, promote and protect the health of the public as specified by
2 state and federal law;

3 (g) Provide regular reports to the board with respect to the performance
4 of health services contractors serving recipients of medical assistance, in-
5 cluding reports of trends in health services and enrollee satisfaction;

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

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

12 (j) In consultation with the Director of the Department of Consumer and
13 Business Services, periodically review and recommend standards and meth-
14 odologies to the Legislative Assembly for:

15 (A) Review of administrative expenses of health insurers;

16 (B) Approval of rates; and

17 (C) Enforcement of rating rules adopted by the Department of Consumer
18 and Business Services;

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

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

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

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

3 *[(o) Implement a process for collecting the health outcome and quality*
4 *measure data identified by the Health Plan Quality Metrics Committee and the*
5 *Behavioral Health Committee and report the data to the Oregon Health Policy*
6 *Board.]*

7 **(o) Report to the Oregon Health Policy Board annually the quality**
8 **measures established by the Health Equity Quality Metrics Committee**
9 **and the quality metrics established by the Behavioral Health Com-**
10 **mittee under ORS 413.017.**

11 (2) The Oregon Health Authority is authorized to:

12 (a) Create an all-claims, all-payer database to collect health care data and
13 monitor and evaluate health care reform in Oregon and to provide compar-
14 ative cost and quality information to consumers, providers and purchasers
15 of health care about Oregon's health care systems and health plan networks
16 in order to provide comparative information to consumers.

17 (b) Develop uniform contracting standards for the purchase of health care,
18 including the following:

19 (A) Uniform quality standards and performance measures;

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

22 (C) Evidence-based effectiveness guidelines for select new technologies
23 and medical equipment;

24 (D) A statewide drug formulary that may be used by publicly funded
25 health benefit plans; and

26 (E) Standards that accept and consider tribal-based practices for mental
27 health and substance abuse prevention, counseling and treatment for persons
28 who are Native American or Alaska Native as equivalent to evidence-based
29 practices.

30 (3) The enumeration of duties, functions and powers in this section is not
31 intended to be exclusive nor to limit the duties, functions and powers im-

1 posed on or vested in the Oregon Health Authority by ORS 413.006 to 413.042,
2 413.610 to 413.613, 415.012 to 415.430, 415.501, 741.001 to 741.540, 741.802 and
3 741.900 or by other statutes.

4 **SECTION 5.** ORS 414.025 is amended to read:

5 414.025. As used in this chapter and ORS chapters 411 and 413, unless the
6 context or a specially applicable statutory definition requires otherwise:

7 (1)(a) “Alternative payment methodology” means a payment other than a
8 fee-for-services payment, used by coordinated care organizations as compen-
9 sation for the provision of integrated and coordinated health care and ser-
10 vices.

11 (b) “Alternative payment methodology” includes, but is not limited to:

12 (A) Shared savings arrangements;

13 (B) Bundled payments; and

14 (C) Payments based on episodes.

15 (2) “Behavioral health assessment” means an evaluation by a behavioral
16 health clinician, in person or using telemedicine, to determine a patient’s
17 need for immediate crisis stabilization.

18 (3) “Behavioral health clinician” means:

19 (a) A licensed psychiatrist;

20 (b) A licensed psychologist;

21 (c) A licensed nurse practitioner with a specialty in psychiatric mental
22 health;

23 (d) A licensed clinical social worker;

24 (e) A licensed professional counselor or licensed marriage and family
25 therapist;

26 (f) A certified clinical social work associate;

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

29 (h) Any other clinician whose authorized scope of practice includes men-
30 tal health diagnosis and treatment.

31 (4) “Behavioral health crisis” means a disruption in an individual’s men-

1 tal or emotional stability or functioning resulting in an urgent need for im-
2 mediate outpatient treatment in an emergency department or admission to
3 a hospital to prevent a serious deterioration in the individual's mental or
4 physical health.

5 (5) "Behavioral health home" means a mental health disorder or substance
6 use disorder treatment organization, as defined by the Oregon Health Au-
7 thority by rule, that provides integrated health care to individuals whose
8 primary diagnoses are mental health disorders or substance use disorders.

9 (6) "Category of aid" means assistance provided by the Oregon Supple-
10 mental Income Program, aid granted under ORS 411.877 to 411.896 and
11 412.001 to 412.069 or federal Supplemental Security Income payments.

12 (7) "Community health worker" means an individual who meets quali-
13 fication criteria adopted by the authority under ORS 414.665 and who:

14 (a) Has expertise or experience in public health;

15 (b) Works in an urban or rural community, either for pay or as a volun-
16 teer in association with a local health care system;

17 (c) To the extent practicable, shares ethnicity, language, socioeconomic
18 status and life experiences with the residents of the community the worker
19 serves;

20 (d) Assists members of the community to improve their health and in-
21 creases the capacity of the community to meet the health care needs of its
22 residents and achieve wellness;

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

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

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

27 (h) May provide direct services such as first aid or blood pressure
28 screening.

29 (8) "Coordinated care organization" means an organization meeting cri-
30 teria adopted by the Oregon Health Authority under ORS 414.572.

31 (9) "Dually eligible for Medicare and Medicaid" means, with respect to

1 eligibility for enrollment in a coordinated care organization, that an indi-
2 vidual is eligible for health services funded by Title XIX of the Social Se-
3 curity Act and is:

4 (a) Eligible for or enrolled in Part A of Title XVIII of the Social Security
5 Act; or

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

7 (10)(a) “Family support specialist” means an individual who meets quali-
8 fication criteria adopted by the authority under ORS 414.665 and who pro-
9 vides supportive services to and has experience parenting a child who:

10 (A) Is a current or former consumer of mental health or addiction treat-
11 ment; or

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

14 (b) A “family support specialist” may be a peer wellness specialist or a
15 peer support specialist.

16 (11) “Global budget” means a total amount established prospectively by
17 the Oregon Health Authority to be paid to a coordinated care organization
18 for the delivery of, management of, access to and quality of the health care
19 delivered to members of the coordinated care organization.

20 (12) “Health insurance exchange” or “exchange” means an American
21 Health Benefit Exchange described in 42 U.S.C. 18031, 18032, 18033 and 18041.

22 (13) “Health services” means at least so much of each of the following
23 as are funded by the Legislative Assembly based upon the prioritized list of
24 health services compiled by the Health Evidence Review Commission under
25 ORS 414.690:

26 (a) Services required by federal law to be included in the [*state’s*] medical
27 assistance program in order for the program to qualify for federal funds;

28 (b) Services provided by a physician as defined in ORS 677.010, a nurse
29 practitioner licensed under ORS 678.375, a behavioral health clinician or
30 other licensed practitioner within the scope of the practitioner’s practice as
31 defined by state law, and ambulance services;

- 1 (c) Prescription drugs;
- 2 (d) Laboratory and X-ray services;
- 3 (e) Medical equipment and supplies;
- 4 (f) Mental health services;
- 5 (g) Chemical dependency services;
- 6 (h) Emergency dental services;
- 7 (i) Nonemergency dental services;
- 8 (j) Provider services, other than services described in paragraphs (a) to
- 9 (i), (k), (L) and (m) of this subsection, defined by federal law that may be
- 10 included in the [state's] medical assistance program;
- 11 (k) Emergency hospital services;
- 12 (L) Outpatient hospital services; and
- 13 (m) Inpatient hospital services.

14 (14) "Income" has the meaning given that term in ORS 411.704.

15 (15)(a) "Integrated health care" means care provided to individuals and

16 their families in a patient centered primary care home or behavioral health

17 home by licensed primary care clinicians, behavioral health clinicians and

18 other care team members, working together to address one or more of the

19 following:

- 20 (A) Mental illness.
- 21 (B) Substance use disorders.
- 22 (C) Health behaviors that contribute to chronic illness.
- 23 (D) Life stressors and crises.
- 24 (E) Developmental risks and conditions.
- 25 (F) Stress-related physical symptoms.
- 26 (G) Preventive care.
- 27 (H) Ineffective patterns of health care utilization.

28 (b) As used in this subsection, "other care team members" includes but

29 is not limited to:

- 30 (A) Qualified mental health professionals or qualified mental health as-
- 31 sociates meeting requirements adopted by the Oregon Health Authority by

1 rule;

2 (B) Peer wellness specialists;

3 (C) Peer support specialists;

4 (D) Community health workers who have completed a state-certified
5 training program;

6 (E) Personal health navigators; or

7 (F) Other qualified individuals approved by the Oregon Health Authority.

8 (16) “Investments and savings” means cash, securities as defined in ORS
9 59.015, negotiable instruments as defined in ORS 73.0104 and such similar
10 investments or savings as the department or the authority may establish by
11 rule that are available to the applicant or recipient to contribute toward
12 meeting the needs of the applicant or recipient.

13 (17) “Medical assistance” means so much of the medical, mental health,
14 preventive, supportive, palliative and remedial care and services as may be
15 prescribed by the authority according to the standards established pursuant
16 to ORS 414.065, including premium assistance under ORS 413.610 to 413.613,
17 414.115 and 414.117, payments made for services provided under an insurance
18 or other contractual arrangement and money paid directly to the recipient
19 for the purchase of health services and for services described in ORS 414.710.

20 (18) “Medical assistance” includes any care or services for any individual
21 who is a patient in a medical institution or any care or services for any in-
22 dividual who has attained 65 years of age or is under 22 years of age, and
23 who is a patient in a private or public institution for mental diseases. Except
24 as provided in ORS 411.439 and 411.447, “medical assistance” does not include
25 care or services for a resident of a nonmedical public institution.

26 (19) “Patient centered primary care home” means a health care team or
27 clinic that is organized in accordance with the standards established by the
28 Oregon Health Authority under ORS 414.655 and that incorporates the fol-
29 lowing core attributes:

30 (a) Access to care;

31 (b) Accountability to consumers and to the community;

- 1 (c) Comprehensive whole person care;
- 2 (d) Continuity of care;
- 3 (e) Coordination and integration of care; and
- 4 (f) Person and family centered care.

5 (20) "Peer support specialist" means any of the following individuals who
6 meet qualification criteria adopted by the authority under ORS 414.665 and
7 who provide supportive services to a current or former consumer of mental
8 health or addiction treatment:

9 (a) An individual who is a current or former consumer of mental health
10 treatment; or

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

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

23 (22) "Person centered care" means care that:

24 (a) Reflects the individual patient's strengths and preferences;

25 (b) Reflects the clinical needs of the patient as identified through an in-
26 dividualized assessment; and

27 (c) Is based upon the patient's goals and will assist the patient in
28 achieving the goals.

29 (23) "Personal health navigator" means an individual who meets quali-
30 fication criteria adopted by the authority under ORS 414.665 and who pro-
31 vides information, assistance, tools and support to enable a patient to make

1 the best health care decisions in the patient’s particular circumstances and
2 in light of the patient’s needs, lifestyle, combination of conditions and de-
3 sired outcomes.

4 [(24) “Prepaid managed care health services organization” means a man-
5 aged dental care, mental health or chemical dependency organization that
6 contracts with the authority under ORS 414.654 or with a coordinated care
7 organization on a prepaid capitated basis to provide health services to medical
8 assistance recipients.]

9 [(25)] **(24)** “Quality measure” means [the health outcome and quality
10 measures and benchmarks identified by the Health Plan Quality Metrics
11 Committee and the metrics and scoring subcommittee] **a standard for meas-**
12 **uring the performance of a coordinated care organization or health**
13 **care provider in the provision of care and services, including, but not**
14 **limited to, the quality measures established by the Health Equity**
15 **Quality Metrics Committee** in accordance with ORS 413.017 (4) [and
16 414.638] and the quality metrics developed by the Behavioral Health Com-
17 mittee in accordance with ORS 413.017 (5).

18 [(26)] **(25)** “Resources” has the meaning given that term in ORS 411.704.
19 For eligibility purposes, “resources” does not include charitable contribu-
20 tions raised by a community to assist with medical expenses.

21 [(27)] **(26)** “Tribal traditional health worker” means an individual who
22 meets qualification criteria adopted by the authority under ORS 414.665 and
23 who:

- 24 (a) Has expertise or experience in public health;
- 25 (b) Works in a tribal community or an urban Indian community, either
26 for pay or as a volunteer in association with a local health care system;
- 27 (c) To the extent practicable, shares ethnicity, language, socioeconomic
28 status and life experiences with the residents of the community the worker
29 serves;
- 30 (d) Assists members of the community to improve their health, including
31 physical, behavioral and oral health, and increases the capacity of the com-

1 munity to meet the health care needs of its residents and achieve wellness;

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

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

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

6 (h) May provide direct services, such as tribal-based practices.

7 [(28)(a)] **(27)** “Youth support specialist” means an individual who meets
8 qualification criteria adopted by the authority under ORS 414.665 and who,
9 based on a similar life experience, provides supportive services to an indi-
10 vidual who:

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

12 (B)(i) Is a current or former consumer of mental health or addiction
13 treatment; or

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

16 (b) A “youth support specialist” may be a peer wellness specialist or a
17 peer support specialist.

18 **SECTION 6.** ORS 414.025, as amended by section 2, chapter 628, Oregon
19 Laws 2021, is amended to read:

20 414.025. As used in this chapter and ORS chapters 411 and 413, unless the
21 context or a specially applicable statutory definition requires otherwise:

22 (1)(a) “Alternative payment methodology” means a payment other than a
23 fee-for-services payment, used by coordinated care organizations as compen-
24 sation for the provision of integrated and coordinated health care and ser-
25 vices.

26 (b) “Alternative payment methodology” includes, but is not limited to:

27 (A) Shared savings arrangements;

28 (B) Bundled payments; and

29 (C) Payments based on episodes.

30 (2) “Behavioral health assessment” means an evaluation by a behavioral
31 health clinician, in person or using telemedicine, to determine a patient’s

1 need for immediate crisis stabilization.

2 (3) “Behavioral health clinician” means:

3 (a) A licensed psychiatrist;

4 (b) A licensed psychologist;

5 (c) A licensed nurse practitioner with a specialty in psychiatric mental
6 health;

7 (d) A licensed clinical social worker;

8 (e) A licensed professional counselor or licensed marriage and family
9 therapist;

10 (f) A certified clinical social work associate;

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

13 (h) Any other clinician whose authorized scope of practice includes men-
14 tal health diagnosis and treatment.

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

20 (5) “Behavioral health home” means a mental health disorder or substance
21 use disorder treatment organization, as defined by the Oregon Health Au-
22 thority by rule, that provides integrated health care to individuals whose
23 primary diagnoses are mental health disorders or substance use disorders.

24 (6) “Category of aid” means assistance provided by the Oregon Supple-
25 mental Income Program, aid granted under ORS 411.877 to 411.896 and
26 412.001 to 412.069 or federal Supplemental Security Income payments.

27 (7) “Community health worker” means an individual who meets quali-
28 fication criteria adopted by the authority under ORS 414.665 and who:

29 (a) Has expertise or experience in public health;

30 (b) Works in an urban or rural community, either for pay or as a volun-
31 teer in association with a local health care system;

1 (c) To the extent practicable, shares ethnicity, language, socioeconomic
2 status and life experiences with the residents of the community the worker
3 serves;

4 (d) Assists members of the community to improve their health and in-
5 creases the capacity of the community to meet the health care needs of its
6 residents and achieve wellness;

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

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

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

11 (h) May provide direct services such as first aid or blood pressure
12 screening.

13 (8) “Coordinated care organization” means an organization meeting cri-
14 teria adopted by the Oregon Health Authority under ORS 414.572.

15 (9) “Dually eligible for Medicare and Medicaid” means, with respect to
16 eligibility for enrollment in a coordinated care organization, that an indi-
17 vidual is eligible for health services funded by Title XIX of the Social Se-
18 curity Act and is:

19 (a) Eligible for or enrolled in Part A of Title XVIII of the Social Security
20 Act; or

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

22 (10)(a) “Family support specialist” means an individual who meets quali-
23 fication criteria adopted by the authority under ORS 414.665 and who pro-
24 vides supportive services to and has experience parenting a child who:

25 (A) Is a current or former consumer of mental health or addiction treat-
26 ment; or

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

29 (b) A “family support specialist” may be a peer wellness specialist or a
30 peer support specialist.

31 (11) “Global budget” means a total amount established prospectively by

1 the Oregon Health Authority to be paid to a coordinated care organization
2 for the delivery of, management of, access to and quality of the health care
3 delivered to members of the coordinated care organization.

4 (12) “Health insurance exchange” or “exchange” means an American
5 Health Benefit Exchange described in 42 U.S.C. 18031, 18032, 18033 and 18041.

6 (13) “Health services” means at least so much of each of the following
7 as are funded by the Legislative Assembly based upon the prioritized list of
8 health services compiled by the Health Evidence Review Commission under
9 ORS 414.690:

10 (a) Services required by federal law to be included in the [*state’s*] medical
11 assistance program in order for the program to qualify for federal funds;

12 (b) Services provided by a physician as defined in ORS 677.010, a nurse
13 practitioner licensed under ORS 678.375, a behavioral health clinician or
14 other licensed practitioner within the scope of the practitioner’s practice as
15 defined by state law, and ambulance services;

16 (c) Prescription drugs;

17 (d) Laboratory and X-ray services;

18 (e) Medical equipment and supplies;

19 (f) Mental health services;

20 (g) Chemical dependency services;

21 (h) Emergency dental services;

22 (i) Nonemergency dental services;

23 (j) Provider services, other than services described in paragraphs (a) to
24 (i), (k), (L) and (m) of this subsection, defined by federal law that may be
25 included in the [*state’s*] medical assistance program;

26 (k) Emergency hospital services;

27 (L) Outpatient hospital services; and

28 (m) Inpatient hospital services.

29 (14) “Income” has the meaning given that term in ORS 411.704.

30 (15)(a) “Integrated health care” means care provided to individuals and
31 their families in a patient centered primary care home or behavioral health

1 home by licensed primary care clinicians, behavioral health clinicians and
2 other care team members, working together to address one or more of the
3 following:

- 4 (A) Mental illness.
- 5 (B) Substance use disorders.
- 6 (C) Health behaviors that contribute to chronic illness.
- 7 (D) Life stressors and crises.
- 8 (E) Developmental risks and conditions.
- 9 (F) Stress-related physical symptoms.
- 10 (G) Preventive care.
- 11 (H) Ineffective patterns of health care utilization.

12 (b) As used in this subsection, “other care team members” includes but
13 is not limited to:

- 14 (A) Qualified mental health professionals or qualified mental health as-
15 sociates meeting requirements adopted by the Oregon Health Authority by
16 rule;
- 17 (B) Peer wellness specialists;
- 18 (C) Peer support specialists;
- 19 (D) Community health workers who have completed a state-certified
20 training program;
- 21 (E) Personal health navigators; or
- 22 (F) Other qualified individuals approved by the Oregon Health Authority.

23 (16) “Investments and savings” means cash, securities as defined in ORS
24 59.015, negotiable instruments as defined in ORS 73.0104 and such similar
25 investments or savings as the department or the authority may establish by
26 rule that are available to the applicant or recipient to contribute toward
27 meeting the needs of the applicant or recipient.

28 (17) “Medical assistance” means so much of the medical, mental health,
29 preventive, supportive, palliative and remedial care and services as may be
30 prescribed by the authority according to the standards established pursuant
31 to ORS 414.065, including premium assistance under ORS 413.610 to 413.613,

1 414.115 and 414.117, payments made for services provided under an insurance
2 or other contractual arrangement and money paid directly to the recipient
3 for the purchase of health services and for services described in ORS 414.710.

4 (18) “Medical assistance” includes any care or services for any individual
5 who is a patient in a medical institution or any care or services for any in-
6 dividual who has attained 65 years of age or is under 22 years of age, and
7 who is a patient in a private or public institution for mental diseases. Except
8 as provided in ORS 411.439 and 411.447, “medical assistance” does not include
9 care or services for a resident of a nonmedical public institution.

10 (19) “Mental health drug” means a type of legend drug, as defined in ORS
11 414.325, specified by the Oregon Health Authority by rule, including but not
12 limited to:

13 (a) Therapeutic class 7 ataractics-tranquilizers; and

14 (b) Therapeutic class 11 psychostimulants-antidepressants.

15 (20) “Patient centered primary care home” means a health care team or
16 clinic that is organized in accordance with the standards established by the
17 Oregon Health Authority under ORS 414.655 and that incorporates the fol-
18 lowing core attributes:

19 (a) Access to care;

20 (b) Accountability to consumers and to the community;

21 (c) Comprehensive whole person care;

22 (d) Continuity of care;

23 (e) Coordination and integration of care; and

24 (f) Person and family centered care.

25 (21) “Peer support specialist” means any of the following individuals who
26 meet qualification criteria adopted by the authority under ORS 414.665 and
27 who provide supportive services to a current or former consumer of mental
28 health or addiction treatment:

29 (a) An individual who is a current or former consumer of mental health
30 treatment; or

31 (b) An individual who is in recovery, as defined by the Oregon Health

1 Authority by rule, from an addiction disorder.

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

12 (23) “Person centered care” means care that:

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

14 (b) Reflects the clinical needs of the patient as identified through an in-
15 dividualized assessment; and

16 (c) Is based upon the patient’s goals and will assist the patient in
17 achieving the goals.

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

24 [(25) “Prepaid managed care health services organization” means a man-
25 aged dental care, mental health or chemical dependency organization that
26 contracts with the authority under ORS 414.654 or with a coordinated care
27 organization on a prepaid capitated basis to provide health services to medical
28 assistance recipients.]

29 [(26)] (25) “Quality measure” means [the health outcome and quality
30 measures and benchmarks identified by the Health Plan Quality Metrics
31 Committee and the metrics and scoring subcommittee] **a standard for meas-**

1 **uring the performance of a coordinated care organization or health**
2 **care provider in the provision of care and services, including, but not**
3 **limited to, the quality measures established by the Health Equity**
4 **Quality Metrics Committee** in accordance with ORS 413.017 (4) [*and*
5 *414.638*] and the quality metrics developed by the Behavioral Health Com-
6 mittee in accordance with ORS 413.017 (5).

7 [(27)] **(26)** “Resources” has the meaning given that term in ORS 411.704.
8 For eligibility purposes, “resources” does not include charitable contribu-
9 tions raised by a community to assist with medical expenses.

10 [(28)] **(27)** “Tribal traditional health worker” means an individual who
11 meets qualification criteria adopted by the authority under ORS 414.665 and
12 who:

- 13 (a) Has expertise or experience in public health;
- 14 (b) Works in a tribal community or an urban Indian community, either
15 for pay or as a volunteer in association with a local health care system;
- 16 (c) To the extent practicable, shares ethnicity, language, socioeconomic
17 status and life experiences with the residents of the community the worker
18 serves;
- 19 (d) Assists members of the community to improve their health, including
20 physical, behavioral and oral health, and increases the capacity of the com-
21 munity to meet the health care needs of its residents and achieve wellness;
- 22 (e) Provides health education and information that is culturally appro-
23 priate to the individuals being served;
- 24 (f) Assists community residents in receiving the care they need;
- 25 (g) May give peer counseling and guidance on health behaviors; and
- 26 (h) May provide direct services, such as tribal-based practices.

27 [(29)(a)] **(28)(a)** “Youth support specialist” means an individual who meets
28 qualification criteria adopted by the authority under ORS 414.665 and who,
29 based on a similar life experience, provides supportive services to an indi-
30 vidual who:

- 31 (A) Is not older than 30 years of age; and

1 (B)(i) Is a current or former consumer of mental health or addiction
2 treatment; or

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

5 (b) A “youth support specialist” may be a peer wellness specialist or a
6 peer support specialist.

7 **SECTION 7.** ORS 414.591 is amended to read:

8 414.591. (1) The Oregon Health Authority shall use, to the greatest extent
9 possible, coordinated care organizations to provide fully integrated physical
10 health services, chemical dependency and mental health services and oral
11 health services. This section, and any contract entered into pursuant to this
12 section, does not affect and may not alter the delivery of Medicaid-funded
13 long term care services.

14 (2) The authority shall execute contracts with coordinated care organiza-
15 tions that meet the criteria adopted by the authority under ORS 414.572.
16 Contracts under this subsection are not subject to ORS chapters 279A and
17 279B, except ORS 279A.250 to 279A.290 and 279B.235.

18 (3)(a) The authority shall establish financial reporting requirements for
19 coordinated care organizations, consistent with ORS 415.115 and 731.574, no
20 less than 90 days before the beginning of the reporting period. The authority
21 shall prescribe requirements and procedures for financial reporting that:

22 (A) Enable the authority to verify that the coordinated care
23 organization’s capital, surplus, reserves and other financial resources are
24 adequate to ensure against the risk of insolvency;

25 (B) Include information on the three highest executive salary and benefit
26 packages of each coordinated care organization;

27 (C) Require quarterly reports to be filed with the authority by May 31,
28 August 31 and November 30;

29 (D) In addition to the annual audited financial statement required by ORS
30 415.115, require an annual report to be filed with the authority by April 30
31 following the end of the period for which data is reported; and

1 (E) Align, to the greatest extent practicable, with the National Associ-
2 ation of Insurance Commissioners' reporting forms to reduce the adminis-
3 trative costs of coordinated care organizations that are also regulated by the
4 Department of Consumer and Business Services or have affiliates that are
5 regulated by the department.

6 (b) The authority shall provide information to coordinated care organiza-
7 tions about the reporting standards of the National Association of Insurance
8 Commissioners and provide training on the reporting standards to the staff
9 of coordinated care organizations who will be responsible for compiling the
10 reports.

11 **(4)(a) The authority shall incorporate the quality measures estab-**
12 **lished by the Health Equity Quality Metrics Committee under ORS**
13 **413.017 into coordinated care organization contracts to hold the coor-**
14 **ordinated care organizations accountable for performance and customer**
15 **satisfaction requirements. The authority shall notify each coordinated**
16 **care organization of any changes in the quality measures at least three**
17 **months before the beginning of the contract period during which the**
18 **new quality measures will be in place.**

19 (b) The authority shall hold coordinated care organizations, contractors
20 and providers accountable for timely submission of [*outcome and quality*]
21 data **on quality measures and other data prescribed by the authority**
22 **by rule**, including but not limited to data described in ORS 442.373[, *pre-*
23 *scribed by the authority by rule*].

24 (c) **The authority may encourage compliance with quality measures**
25 **and data reporting standards by withholding a percentage of each co-**
26 **ordinated care organization's monthly global payment during a calen-**
27 **dar year and paying all or a portion of the amount withheld to the**
28 **coordinated care organization in the following year based on the co-**
29 **ordinated care organization's compliance with quality measures and**
30 **data reporting standards. The withholdings and payments are not**
31 **subject to the Oregon Department of Administrative Service's guid-**

1 **ance on accounting and financial reporting for the withholding of state**
2 **payments or distributions from nonstate entities as set forth in the**
3 **Oregon Accounting Manual.**

4 (5) The authority shall require compliance with the provisions of sub-
5 sections (3) and (4) of this section as a condition of entering into a contract
6 with a coordinated care organization. A coordinated care organization, con-
7 tractor or provider that fails to comply with subsection (3) or (4) of this
8 section may be subject to sanctions, including but not limited to civil pen-
9 alties, barring any new enrollment in the coordinated care organization and
10 termination of the contract.

11 (6)(a) The authority shall adopt rules and procedures to ensure that if a
12 rural health clinic provides a health service to a member of a coordinated
13 care organization, and the rural health clinic is not participating in the
14 member's coordinated care organization, the rural health clinic receives total
15 aggregate payments from the member's coordinated care organization, other
16 payers on the claim and the authority that are no less than the amount the
17 rural health clinic would receive in the authority's fee-for-service payment
18 system. The authority shall issue a payment to the rural health clinic in
19 accordance with this subsection within 45 days of receipt by the authority
20 of a completed billing form.

21 (b) "Rural health clinic," as used in this subsection, shall be defined by
22 the authority by rule and shall conform, as far as practicable or applicable
23 in this state, to the definition of that term in 42 U.S.C. 1395x(aa)(2).

24 (7) The authority may contract with providers other than coordinated
25 care organizations to provide integrated and coordinated health care in areas
26 that are not served by a coordinated care organization or where the
27 organization's provider network is inadequate. Contracts authorized by this
28 subsection are not subject to ORS chapters 279A and 279B, except ORS
29 279A.250 to 279A.290 and 279B.235.

30 (8) The aggregate expenditures by the authority for health services pro-
31 vided pursuant to this chapter may not exceed the total dollars appropriated

1 for health services under this chapter.

2 (9) Actions taken by providers, potential providers, contractors and bid-
3 ders in specific accordance with this chapter in forming consortiums or in
4 otherwise entering into contracts to provide health care services shall be
5 performed pursuant to state supervision and shall be considered to be con-
6 ducted at the direction of this state, shall be considered to be lawful trade
7 practices and may not be considered to be the transaction of insurance for
8 purposes of the Insurance Code.

9 (10) Health care providers contracting to provide services under this
10 chapter shall advise a patient of any service, treatment or test that is med-
11 ically necessary but not covered under the contract if an ordinarily careful
12 practitioner in the same or similar community would do so under the same
13 or similar circumstances.

14 (11) A coordinated care organization shall provide information to a
15 member as prescribed by the authority by rule, including but not limited to
16 written information, within 30 days of enrollment with the coordinated care
17 organization about available providers.

18 (12) Each coordinated care organization shall work to provide assistance
19 that is culturally and linguistically appropriate to the needs of the member
20 to access appropriate services and participate in processes affecting the
21 member's care and services.

22 (13) Each coordinated care organization shall provide upon the request
23 of a member or prospective member annual summaries of the organization's
24 aggregate data regarding:

25 (a) Grievances and appeals; and

26 (b) Availability and accessibility of services provided to members.

27 (14) A coordinated care organization may not limit enrollment in a ge-
28 ographic area based on the zip code of a member or prospective member.

29 **SECTION 8.** ORS 414.686 is amended to read:

30 414.686. (1) A coordinated care organization shall provide an initial health
31 assessment on any child enrolled in the coordinated care organization who

1 is in the custody of the Department of Human Services no later than 60 days
2 after the date that the Oregon Health Authority notifies the coordinated care
3 organization that the child has been taken into the department's custody.
4 [*The assessment must be performed in accordance with metrics established by*
5 *the metrics and scoring subcommittee created in ORS 414.638.*]

6 (2) If a child has not received an initial health assessment by the date
7 specified in subsection (1) of this section, the coordinated care organization
8 shall act affirmatively to locate the child and make arrangements for an in-
9 itial health assessment.

10 **SECTION 9.** ORS 417.721 is amended to read:

11 417.721. The Oregon Health Authority, the [*Health Plan Quality Metrics*
12 *Committee*] **committees established under ORS 413.017** and the Early
13 Learning Council shall work collaboratively with coordinated care organ-
14 izations [*to develop performance metrics for prenatal care, delivery and infant*
15 *care*] **on quality measures, as defined in ORS 414.025**, that align with
16 early learning outcomes.

17 **SECTION 10.** Section 2, chapter 575, Oregon Laws 2015, as amended by
18 section 1, chapter 384, Oregon Laws 2017, and section 13, chapter 489, Oregon
19 Laws 2017, is amended to read:

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

21 (a) "Carrier" means an insurer that offers a health benefit plan, as de-
22 fined in ORS 743B.005.

23 (b) "Coordinated care organization" has the meaning given that term in
24 ORS 414.025.

25 (c) "Primary care" means family medicine, general internal medicine,
26 naturopathic medicine, obstetrics and gynecology, pediatrics or general psy-
27 chiatry.

28 (d) "Primary care provider" includes:

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

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

3 (2)(a) The Oregon Health Authority shall convene a primary care payment
4 reform collaborative to advise and assist in the implementation of a Primary
5 Care Transformation Initiative to:

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

8 (i) Increase the investment in primary care;

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

10 (iii) Continue to improve reimbursement methods, including by investing
11 in the social determinants of health;

12 (B) Increase investment in primary care without increasing costs to con-
13 sumers or increasing the total cost of health care;

14 (C) Provide technical assistance to clinics and payers in implementing the
15 initiative;

16 (D) Aggregate the data from and align the metrics used in the initiative
17 with the work of the [*Health Plan Quality Metrics*] **Health Equity Quality**
18 **Metrics** Committee established in ORS 413.017;

19 (E) Facilitate the integration of primary care behavioral and physical
20 health care; and

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

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

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

25 (a) Primary care providers;

26 (b) Health care consumers;

27 (c) Experts in primary care contracting and reimbursement;

28 (d) Independent practice associations;

29 (e) Behavioral health treatment providers;

30 (f) Third party administrators;

31 (g) Employers that offer self-insured health benefit plans;

- 1 (h) The Department of Consumer and Business Services;
- 2 (i) Carriers;
- 3 (j) A statewide organization for mental health professionals who provide
- 4 primary care;
- 5 (k) A statewide organization representing federally qualified health cen-
- 6 ters;
- 7 (L) A statewide organization representing hospitals and health systems;
- 8 (m) A statewide professional association for family physicians;
- 9 (n) A statewide professional association for physicians;
- 10 (o) A statewide professional association for nurses; and
- 11 (p) The Centers for Medicare and Medicaid Services.

12 (4) The primary care payment reform collaborative shall annually report
13 to the Oregon Health Policy Board and to the Legislative Assembly on the
14 achievement of the primary care spending targets in ORS [414.625] **414.572**
15 and 743.010 and the implementation of the Primary Care Transformation In-
16 itiative.

17 (5) A coordinated care organization shall report to the authority, no later
18 than October 1 of each year, the proportion of the organization's total med-
19 ical costs that are allocated to primary care.

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

23 **SECTION 11.** ORS 413.011 is amended to read:

24 413.011. (1) The duties of the Oregon Health Policy Board are to:

25 (a) Be the policy-making and oversight body for the Oregon Health Au-
26 thority established in ORS 413.032 and all of the authority's departmental
27 divisions.

28 (b) Develop and submit a plan to the Legislative Assembly to provide and
29 fund access to affordable, quality health care for all Oregonians.

30 (c) Develop a program to provide health insurance premium assistance to
31 all low and moderate income individuals who are legal residents of Oregon.

1 (d) Publish [*health outcome and*] quality measure data collected by the
2 Oregon Health Authority at aggregate levels that do not disclose information
3 otherwise protected by law. The information published must report, for each
4 coordinated care organization and each health benefit plan sold through the
5 health insurance exchange or offered by the Oregon Educators Benefit Board
6 or the Public Employees' Benefit Board:

7 (A) Quality measures;

8 (B) Costs;

9 (C) Health outcomes; and

10 (D) Other information that is necessary for members of the public to
11 evaluate the value of health services delivered by each coordinated care or-
12 ganization and by each health benefit plan.

13 (e) Establish evidence-based clinical standards and practice guidelines
14 that may be used by providers.

15 (f) Approve and monitor community-centered health initiatives described
16 in ORS 413.032 (1)(h) that are consistent with public health goals, strategies,
17 programs and performance standards adopted by the Oregon Health Policy
18 Board to improve the health of all Oregonians, and to regularly report to the
19 Legislative Assembly on the accomplishments and needed changes to the in-
20 itiatives.

21 (g) Establish cost containment mechanisms to reduce health care costs.

22 (h) Ensure that Oregon's health care workforce is sufficient in numbers
23 and training to meet the demand that will be created by the expansion in
24 health coverage, health care system transformations, an increasingly diverse
25 population and an aging workforce.

26 (i) Work with the Oregon congressional delegation to advance the
27 adoption of changes in federal law or policy to promote Oregon's compre-
28 hensive health reform plan.

29 (j) Establish a health benefit package in accordance with ORS 741.340 to
30 be used as the baseline for all health benefit plans offered through the health
31 insurance exchange.

1 (k) Investigate and report annually to the Legislative Assembly on the
2 feasibility and advisability of future changes to the health insurance market
3 in Oregon, including but not limited to the following:

4 (A) A requirement for every resident to have health insurance coverage.

5 (B) A payroll tax as a means to encourage employers to continue provid-
6 ing health insurance to their employees.

7 (L) Meet cost-containment goals by structuring reimbursement rates to
8 reward comprehensive management of diseases, quality outcomes and the ef-
9 ficient use of resources by promoting cost-effective procedures, services and
10 programs including, without limitation, preventive health, dental and pri-
11 mary care services, web-based office visits, telephone consultations and tele-
12 medicine consultations.

13 (m) Oversee the expenditure of moneys from the Health Care Provider
14 Incentive Fund to support grants to primary care providers and rural health
15 practitioners, to increase the number of primary care educators and to sup-
16 port efforts to create and develop career ladder opportunities.

17 (n) Work with the Public Health Benefit Purchasers Committee, admin-
18 istrators of the medical assistance program and the Department of Cor-
19 rections to identify uniform contracting standards for health benefit plans
20 that achieve maximum quality and cost outcomes and align the contracting
21 standards for all state programs to the greatest extent practicable.

22 (o) Work with the Health Information Technology Oversight Council to
23 foster health information technology systems and practices that promote the
24 Oregon Integrated and Coordinated Health Care Delivery System established
25 by ORS 414.570 and align health information technology systems and prac-
26 tices across this state.

27 (2) The Oregon Health Policy Board is authorized to:

28 (a) Subject to the approval of the Governor, organize and reorganize the
29 authority as the board considers necessary to properly conduct the work of
30 the authority.

31 (b) Submit directly to the Legislative Counsel, no later than October 1

1 of each even-numbered year, requests for measures necessary to provide
2 statutory authorization to carry out any of the board's duties or to imple-
3 ment any of the board's recommendations. The measures may be filed prior
4 to the beginning of the legislative session in accordance with the rules of
5 the House of Representatives and the Senate.

6 (3) If the board or the authority is unable to perform, in whole or in part,
7 any of the duties described in ORS 413.006 to 413.042 and 741.340 without
8 federal approval, the authority is authorized to request, in accordance with
9 ORS 413.072, waivers or other approval necessary to perform those duties.
10 The authority shall implement any portions of those duties not requiring
11 legislative authority or federal approval, to the extent practicable.

12 (4) The enumeration of duties, functions and powers in this section is not
13 intended to be exclusive nor to limit the duties, functions and powers im-
14 posed on the board by ORS 413.006 to 413.042 and 741.340 and by other stat-
15 utes.

16 (5) The board shall consult with the Department of Consumer and Busi-
17 ness Services in completing the tasks set forth in subsection (1)(j) and (k)(A)
18 of this section.

19 **SECTION 12.** ORS 243.135, as amended by section 16, chapter 489, Oregon
20 Laws 2017, section 12, chapter 2, Oregon Laws 2019, and section 2, chapter
21 484, Oregon Laws 2019, is amended to read:

22 243.135. (1) Notwithstanding any other benefit plan contracted for and
23 offered by the Public Employees' Benefit Board, the board shall contract for
24 a health benefit plan or plans best designed to meet the needs and provide
25 for the welfare of eligible employees, the state and the local governments.
26 In considering whether to enter into a contract for a plan, the board shall
27 place emphasis on:

- 28 (a) Employee choice among high quality plans;
- 29 (b) A competitive marketplace;
- 30 (c) Plan performance and information;
- 31 (d) Employer flexibility in plan design and contracting;

- 1 (e) Quality customer service;
- 2 (f) Creativity and innovation;
- 3 (g) Plan benefits as part of total employee compensation;
- 4 (h) The improvement of employee health; and
- 5 (i) [*Health outcome and*] Quality measures, [*described in*] **established**
- 6 **under** ORS 413.017 (4), that are reported by the plan.

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

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

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

23 (5) In developing any health benefit plan, the board may provide an option
24 of additional coverage for eligible employees and their family members at an
25 additional cost or premium.

26 (6) Transfer of enrollment from one plan to another shall be open to all
27 eligible employees and their family members under rules adopted by the
28 board. Because of the special problems that may arise in individual instances
29 under comprehensive group practice plan coverage involving acceptable
30 provider-patient relations between a particular panel of providers and par-
31 ticular eligible employees and their family members, the board shall provide

1 a procedure under which any eligible employee may apply at any time to
2 substitute a health service benefit plan for participation in a comprehensive
3 group practice benefit plan.

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

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

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

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

21 (10) If the board spends less than 12 percent of its total medical expendi-
22 tures in self-insured health benefit plans on payments for primary care, the
23 board shall implement a plan for increasing the percentage of total medical
24 expenditures spent on payments for primary care by at least one percent each
25 year.

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

31 **SECTION 13.** ORS 243.866, as amended by section 17, chapter 489, Oregon

1 Laws 2017, and section 4, chapter 484, Oregon Laws 2019, is amended to read:

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

- 6 (a) Employee choice among high-quality plans;
- 7 (b) Encouragement of a competitive marketplace;
- 8 (c) Plan performance and information;
- 9 (d) District and local government flexibility in plan design and contract-
10 ing;
- 11 (e) Quality customer service;
- 12 (f) Creativity and innovation;
- 13 (g) Plan benefits as part of total employee compensation;
- 14 (h) Improvement of employee health; and
- 15 (i) [*Health outcome and*] Quality measures, [*described in*] **established**
16 **under** ORS 413.017 (4), that are reported by the plan.

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

25 (3) When appropriate, the board shall provide options under which an el-
26 igible employee may arrange coverage for family members under a benefit
27 plan.

28 (4) A district or a local government shall provide that payroll deductions
29 for benefit plan costs that are not payable by the district or local govern-
30 ment may be made upon receipt of a signed authorization from the employee
31 indicating an election to participate in the benefit plan or plans selected and

1 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
3 additional coverage for eligible employees and family members at an addi-
4 tional premium.

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

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

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

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

24 (b) The board shall adopt policies and practices designed to limit the an-
25 nual increase in premium amounts paid for contracted health benefit plans
26 to 3.4 percent.

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

1 (11) If the board spends less than 12 percent of its total medical expendi-
2 tures in self-insured health benefit plans on payments for primary care, the
3 board shall implement a plan for increasing the percentage of total medical
4 expenditures spent on payments for primary care by at least one percent each
5 year.

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

11
12 **DISCONTINUANCE OF STAND-ALONE PREPAID**
13 **MANAGED CARE HEALTH SERVICES ORGANIZATIONS**

14
15 **SECTION 14.** ORS 743B.470 is amended to read:

16 743B.470. (1) For the purposes of this section:

17 (a) "Health insurer" or "insurer" means an employee benefit plan, self-
18 insured plan, managed care organization or group health plan, a third party
19 administrator, fiscal intermediary or pharmacy benefit manager of the plan
20 or organization, or other party that is by statute, contract or agreement le-
21 gally responsible for payment of a claim for a health care item or service.

22 [(b) "Medicaid" means medical assistance provided under 42 U.S.C. 1396a
23 (section 1902 of the Social Security Act).]

24 (b) "Medical assistance" has the meaning given that term in ORS
25 414.025.

26 (c) "State Medicaid agency" means a state agency responsible for
27 administering Medicaid under 42 U.S.C. 1396a (section 1902 of the So-
28 cial Security Act).

29 (2) A health insurer is prohibited from considering the availability or el-
30 igibility for medical assistance in this or any other state [under Medicaid]
31 when considering eligibility for coverage or making payments under its

1 group or individual plan for eligible enrollees, subscribers, policyholders or
2 certificate holders.

3 (3) To the extent that payment for covered expenses has been made under
4 the [*state Medicaid*] **medical assistance** program for health care items or
5 services furnished to an individual, in any case when a third party has a
6 legal liability to make payments, the state is considered to have acquired the
7 rights of the individual to payment by any other party for those health care
8 items or services.

9 (4) An insurer may not deny a claim submitted by the state Medicaid
10 agency[, *a prepaid managed care health services organization, as defined in*
11 *ORS 414.025,*] or a coordinated care organization, as defined in ORS 414.025,
12 under subsection (3) of this section based on the date of submission of the
13 claim, the type or format of the claim form or a failure to present proper
14 documentation at the point of sale that is the basis of the claim if:

15 (a) The claim is submitted by the agency[, *the prepaid managed care*
16 *health services organization*] or the coordinated care organization within the
17 three-year period beginning on the date on which the health care item or
18 service was furnished; and

19 (b) Any action by the agency[, *the prepaid managed care health services*
20 *organization*] or the coordinated care organization to enforce its rights with
21 respect to the claim is commenced within six years of the agency's or
22 organization's submission of the claim.

23 (5) An insurer must provide to the state Medicaid agency[, *a prepaid*
24 *managed care health services organization*] or a coordinated care organiza-
25 tion, upon request, the following information:

26 (a) The period during which a [*Medicaid*] **medical assistance** recipient,
27 the spouse or dependents may be or may have been covered by the plan;

28 (b) The nature of coverage that is or was provided by the plan; and

29 (c) The name, address and identifying numbers of the plan.

30 (6) An insurer may not deny enrollment of a child under the group or
31 individual health plan of the child's parent on the ground that:

1 (a) The child was born out of wedlock;

2 (b) The child is not claimed as a dependent on the parent's federal tax
3 return; or

4 (c) The child does not reside with the child's parent or in the insurer's
5 service area.

6 (7) When a child has group or individual health coverage through an
7 insurer of a noncustodial parent, the insurer must:

8 (a) Provide such information to the custodial parent as may be necessary
9 for the child to obtain benefits through that coverage;

10 (b) Permit the custodial parent or the provider, with the custodial
11 parent's approval, to submit claims for covered services without the approval
12 of the noncustodial parent; and

13 (c) Make payments on claims submitted in accordance with paragraph (b)
14 of this subsection directly to the custodial parent, the provider or, if a claim
15 is filed by the state Medicaid agency, *a prepaid managed care health services*
16 *organization*] or a coordinated care organization, directly to the agency or
17 the organization.

18 (8) When a parent is required by a court or administrative order to pro-
19 vide health coverage for a child, and the parent is eligible for family health
20 coverage, the insurer must:

21 (a) Permit the parent to enroll, under the family coverage, a child who
22 is otherwise eligible for the coverage without regard to any enrollment sea-
23 son restrictions;

24 (b) If the parent is enrolled but fails to make application to obtain cov-
25 erage for the child, enroll the child under family coverage upon application
26 of the child's other parent, the state [*agency administering the Medicaid*
27 *program*] **Medicaid agency** or the state agency administering 42 U.S.C. 651
28 to 669, the child support enforcement program; and

29 (c) Not disenroll or eliminate coverage of the child unless the insurer is
30 provided satisfactory written evidence that:

31 (A) The court or administrative order is no longer in effect; or

1 (B) The child is or will be enrolled in comparable health coverage through
2 another insurer which will take effect not later than the effective date of
3 disenrollment.

4 (9) An insurer may not impose requirements on a state agency that has
5 been assigned the rights of an individual eligible for medical assistance
6 [*under Medicaid*] and covered for health benefits from the insurer if the re-
7 quirements are different from requirements applicable to an agent or
8 assignee of any other individual so covered.

9 (10) The provisions of ORS 743A.001 do not apply to this section.

10 **SECTION 15.** ORS 192.395 is amended to read:

11 192.395. A record of an agency of the executive department as defined in
12 ORS 174.112 that contains the following information is a public record sub-
13 ject to inspection under ORS 192.314 and is not exempt from disclosure under
14 ORS 192.345 or 192.355 except to the extent that the record discloses infor-
15 mation about an individual's health or is proprietary to a person:

16 (1) The amounts determined by an independent actuary retained by the
17 agency to cover the costs of providing each of the following health services
18 under ORS [*414.591, 414.631 and 414.688 to 414.745*] **chapter 414** for the six
19 months preceding the report:

20 (a) Inpatient hospital services;

21 (b) Outpatient hospital services;

22 (c) Laboratory and X-ray services;

23 (d) Physician and other licensed practitioner services;

24 (e) Prescription drugs;

25 (f) Dental services;

26 (g) Vision services;

27 (h) Mental health services;

28 (i) Chemical dependency services;

29 (j) Durable medical equipment and supplies; and

30 (k) Other health services provided under a coordinated care organization
31 contract under ORS 414.591 [*or a contract with a prepaid managed care health*

1 *services organization, as defined in ORS 414.025*;

2 (2) The amounts the agency and each contractor have paid under each
3 coordinated care organization contract under ORS 414.591 [*or prepaid man-*
4 *aged care health services organization contract*] for administrative costs and
5 the provision of each of the health services described in subsection (1) of this
6 section for the six months preceding the report;

7 (3) Any adjustments made to the amounts reported under this section to
8 account for geographic or other differences in providing the health services;
9 and

10 (4) The numbers of individuals served under each coordinated care or-
11 ganization contract [*or prepaid managed care health services organization*
12 *contract*], listed by category of individual.

13 **SECTION 16.** ORS 192.579 is amended to read:

14 192.579. (1) As used in this section, “entity” means a health care
15 provider[,] **or** a coordinated care organization, as defined in ORS 414.025 [*or*
16 *a prepaid managed care health services organization, as defined in ORS*
17 *414.025*], that provides health care to an individual, if the care is paid for
18 by a state health plan.

19 (2) Notwithstanding ORS 179.505, an entity may disclose the identity of
20 an individual who receives health care from the entity without obtaining an
21 authorization from the individual, or a personal representative of the indi-
22 vidual, to another entity for the purpose of coordinating the health care and
23 treatment provided to the individual by either entity.

24 **SECTION 17.** ORS 413.550, as amended by section 8, chapter 453, Oregon
25 Laws 2021, is amended to read:

26 413.550. As used in ORS 413.550 to 413.559:

27 (1) “Certified health care interpreter” means an individual who has been
28 approved and certified by the Oregon Health Authority under ORS 413.558.

29 (2) “Coordinated care organization” has the meaning given that term in
30 ORS 414.025.

31 (3) “Health care” means medical, surgical, oral or hospital care or any

1 other remedial care recognized by state law, including physical and behav-
2 ioral health care.

3 (4)(a) "Health care interpreter" means an individual who is readily able
4 to:

5 (A) Communicate in English and communicate with a person with limited
6 English proficiency or who communicates in signed language;

7 (B) Accurately interpret the oral statements of a person with limited
8 English proficiency, or the statements of a person who communicates in
9 signed language, into English;

10 (C) Accurately interpret oral statements in English to a person with
11 limited English proficiency or who communicates in signed language;

12 (D) Sight translate documents from a person with limited English profi-
13 ciency; and

14 (E) Interpret the oral statements of other persons into the language of the
15 person with limited English proficiency or into signed language.

16 (b) "Health care interpreter" also includes an individual who can provide
17 the services described in paragraph (a) of this subsection using relay or in-
18 direct interpretation.

19 (5) "Health care interpreter registry" means the registry described in ORS
20 413.558 that is administered by the authority.

21 (6) "Health care provider" means any of the following that are reimbursed
22 with public funds, in whole or in part:

23 (a) An individual licensed or certified by the:

24 (A) State Board of Examiners for Speech-Language Pathology and
25 Audiology;

26 (B) State Board of Chiropractic Examiners;

27 (C) State Board of Licensed Social Workers;

28 (D) Oregon Board of Licensed Professional Counselors and Therapists;

29 (E) Oregon Board of Dentistry;

30 (F) State Board of Massage Therapists;

31 (G) Oregon Board of Naturopathic Medicine;

- 1 (H) Oregon State Board of Nursing;
2 (I) Oregon Board of Optometry;
3 (J) State Board of Pharmacy;
4 (K) Oregon Medical Board;
5 (L) Occupational Therapy Licensing Board;
6 (M) Oregon Board of Physical Therapy;
7 (N) Oregon Board of Psychology;
8 (O) Board of Medical Imaging;
9 (P) State Board of Direct Entry Midwifery;
10 (Q) Respiratory Therapist and Polysomnographic Technologist Licensing
11 Board;
12 (R) Board of Registered Polysomnographic Technologists;
13 (S) Board of Licensed Dietitians; and
14 (T) State Mortuary and Cemetery Board;
15 (b) An emergency medical services provider licensed by the Oregon Health
16 Authority under ORS 682.216;
17 (c) A clinical laboratory licensed under ORS 438.110;
18 (d) A health care facility as defined in ORS 442.015;
19 (e) A home health agency licensed under ORS 443.015;
20 (f) A hospice program licensed under ORS 443.860; or
21 (g) Any other person that provides health care or that bills for or is
22 compensated for health care provided, in the normal course of business.
23 (7) “Interpretation service company” means an entity, or a person acting
24 on behalf of an entity, that is in the business of arranging for health care
25 interpreters to work with health care providers in this state.
26 (8) “Person with limited English proficiency” means a person who, by
27 reason of place of birth or culture, communicates in a language other than
28 English and does not communicate in English with adequate ability to com-
29 municate effectively with a health care provider.
30 [(9) “Prepaid managed care health services organization” has the meaning
31 given that term in ORS 414.025.]

1 [(10)] (9) “Qualified health care interpreter” means an individual who has
2 been issued a valid letter of qualification from the authority under ORS
3 413.558.

4 [(11)] (10) “Sight translate” means to translate a written document into
5 spoken or signed language.

6 **SECTION 18.** ORS 414.430 is amended to read:

7 414.430. (1) The Oregon Health Authority shall prescribe by rule appro-
8 priate time frames within which a pregnant medical assistance recipient
9 whose medical assistance is reimbursed on a fee-for-service basis and who
10 needs general or specialty dental care must have the opportunity to be seen,
11 or referred for, and provided:

- 12 (a) Emergency dental services;
- 13 (b) Urgent dental services;
- 14 (c) Routine dental services; and
- 15 (d) An initial dental screening or examination.

16 (2) The time frames prescribed by the authority for recipients whose
17 medical assistance is reimbursed on a fee-for-service basis shall be the same
18 as or shorter than the time frames for pregnant recipients enrolled in coor-
19 dinated care organizations [*and dental care organizations*].

20 **SECTION 19.** ORS 414.619 is amended to read:

21 414.619. (1) The Oregon Health Authority and the Department of Human
22 Services shall cooperate with each other by coordinating actions and re-
23 sponsibilities necessary to implement the Oregon Integrated and Coordinated
24 Health Care Delivery System established in ORS 414.570.

25 (2) The authority and the department may delegate to each other any
26 duties, functions or powers that the authority or department are authorized
27 to perform if necessary to carry out this section and ORS 414.572, 414.598,
28 414.605, 414.607, 414.632, [414.638, 414.654,] 414.655 and 414.665.

29 **SECTION 20.** ORS 414.631 is amended to read:

30 414.631. (1) Except as provided in subsections [(2), (3), (4) and (5)] (2) and
31 (3) of this section and ORS 414.632 (2), a person who is eligible for or re-

1 ceiving health services must be enrolled in a coordinated care organization
2 to receive the health services for which the person is eligible. For purposes
3 of this subsection, Medicaid-funded long term care services do not constitute
4 health services.

5 (2) [Subsections (1) and (4)] **Subsection (1)** of this section [do] **does** not
6 apply to:

7 (a) A person who is a noncitizen and who is eligible only for labor and
8 delivery services and emergency treatment services;

9 (b) A person who is an American Indian and Alaska Native beneficiary;

10 (c) An individual described in ORS 414.632 (2) who is dually eligible for
11 Medicare and Medicaid and enrolled in a program of all-inclusive care for
12 the elderly; and

13 (d) A person whom the Oregon Health Authority may by rule exempt from
14 the mandatory enrollment requirement of subsection (1) of this section, in-
15 cluding but not limited to:

16 (A) A person who is also eligible for Medicare;

17 (B) A woman in her third trimester of pregnancy at the time of enroll-
18 ment;

19 (C) A person under 19 years of age who has been placed in adoptive or
20 foster care out of state;

21 (D) A person under 18 years of age who is medically fragile and who has
22 special health care needs;

23 (E) A person receiving services under the Medically Involved Home-Care
24 Program created by ORS 417.345 (1); and

25 (F) A person with major medical coverage.

26 (3) Subsection (1) of this section does not apply to a person who resides
27 in an area that is not served by a coordinated care organization or where
28 the organization's provider network is inadequate.

29 [(4) *In any area that is not served by a coordinated care organization but*
30 *is served by a prepaid managed care health services organization, a person*
31 *must enroll with the prepaid managed care health services organization to re-*

1 *ceive any of the health services offered by the prepaid managed care health*
2 *services organization.]*

3 [(5)] (4) As used in this section, “American Indian and Alaska Native
4 beneficiary” means:

5 (a) A member of a federally recognized Indian tribe;

6 (b) An individual who resides in an urban center and:

7 (A) Is a member of a tribe, band or other organized group of Indians, in-
8 cluding those tribes, bands or groups whose recognition was terminated since
9 1940 and those recognized now or in the future by the state in which the
10 member resides, or who is a descendant in the first or second degree of such
11 a member;

12 (B) Is an Eskimo or Aleut or other Alaska Native; or

13 (C) Is determined to be an Indian under regulations promulgated by the
14 United States Secretary of the Interior;

15 (c) A person who is considered by the United States Secretary of the In-
16 terior to be an Indian for any purpose; or

17 (d) An individual who is considered by the United States Secretary of
18 Health and Human Services to be an Indian for purposes of eligibility for
19 Indian health care services, including as a California Indian, Eskimo, Aleut
20 or other Alaska Native.

21 **SECTION 21.** ORS 414.764 is amended to read:

22 414.764. (1) The Oregon Health Authority may reimburse a pharmacist or
23 pharmacy for any health service:

24 (a) Provided to a medical assistance recipient who is not enrolled in a
25 coordinated care organization [*or a prepaid managed care health services or-*
26 *ganization*];

27 (b) That is within the lawful scope of practice of a pharmacist; and

28 (c) If the authority determines the service is within the types and extent
29 of health care and services to be provided to medical assistance recipients
30 under ORS 414.065.

31 (2) A coordinated care organization may reimburse a pharmacist or

1 pharmacy for any health service:

2 (a) Provided to a medical assistance recipient who is enrolled in the co-
3 ordinated care organization [*or a prepaid managed care health services or-*
4 *ganization*] that enters into a clinical pharmacy agreement with the
5 pharmacist or pharmacy; and

6 (b) That is within the lawful scope of practice of a pharmacist.

7 **SECTION 22.** ORS 414.880 is amended to read:

8 414.880. (1) As used in this section and ORS 414.882 and 414.902:

9 [(a) "*Managed care organization*" means:]

10 [(A) *A coordinated care organization as defined in ORS 414.025; and*]

11 [(B) *A prepaid managed care health services organization as defined in*
12 *ORS 414.025.*]

13 (a) **"Coordinated care organization" has the meaning given that**
14 **term in ORS 414.025.**

15 (b) "Premium equivalent" means the payments made to [*the managed*] a
16 **coordinated** care organization by the Oregon Health Authority for providing
17 health services under ORS chapter 414.

18 (2) No later than 45 days following the end of a calendar quarter, a
19 [*managed*] **coordinated** care organization shall pay an assessment at a rate
20 of two percent of the gross amount of premium equivalents received during
21 that calendar quarter.

22 (3) The assessment shall be paid to the authority in a manner and form
23 prescribed by the authority.

24 (4) Assessments received by the authority under this section shall be paid
25 into the State Treasury and credited to the Health System Fund established
26 under section 2, chapter 538, Oregon Laws 2017.

27 (5) The assessment imposed under this section is in addition to and not
28 in lieu of any tax, surcharge or other assessment imposed on a [*managed*]
29 **coordinated** care organization.

30 **SECTION 23.** ORS 414.902 is amended to read:

31 414.902. (1) If a [*managed*] **coordinated** care organization fails to timely

1 pay an assessment under ORS 414.880, the Oregon Health Authority shall
2 impose a penalty on the [*managed*] **coordinated** care organization of up to
3 \$500 per day of delinquency. The total amount of penalties imposed under
4 this section for a calendar quarter may not exceed five percent of the as-
5 sessment due for that calendar quarter.

6 (2) Any penalty imposed under this section is in addition to and not in
7 lieu of the assessment imposed under ORS 414.880.

8 (3) Penalties received by the authority under this section shall be paid
9 into the State Treasury and credited to the Health System Fund established
10 under section 2, chapter 538, Oregon Laws 2017.

11 **SECTION 24.** ORS 415.500 is amended to read:

12 415.500. As used in this section and ORS 415.501 and 415.505:

13 (1) “Corporate affiliation” has the meaning prescribed by the Oregon
14 Health Authority by rule, including:

15 (a) Any relationship between two organizations that reflects, directly or
16 indirectly, a partial or complete controlling interest or partial or complete
17 corporate control; and

18 (b) Transactions that merge tax identification numbers or corporate
19 governance.

20 (2) “Essential services” means:

21 (a) Services that are funded on the prioritized list described in ORS
22 414.690; and

23 (b) Services that are essential to achieve health equity.

24 (3) “Health benefit plan” has the meaning given that term in ORS
25 743B.005.

26 (4)(a) “Health care entity” includes:

27 (A) An individual health professional licensed or certified in this state;

28 (B) A hospital, as defined in ORS 442.015, or hospital system, as defined
29 by the authority by rule;

30 (C) A carrier, as defined in ORS 743B.005, that offers a health benefit plan
31 in this state;

1 (D) A Medicare Advantage plan;

2 (E) A coordinated care organization [*or a prepaid managed care health*
3 *services organization, as both terms are*], **as** defined in ORS 414.025; and

4 (F) Any other entity that has as a primary function the provision of
5 health care items or services or that is a parent organization of, or is an
6 entity closely related to, an entity that has as a primary function the pro-
7 vision of health care items or services.

8 (b) “Health care entity” does not include:

9 (A) Long term care facilities, as defined in ORS 442.015.

10 (B) Facilities licensed and operated under ORS 443.400 to 443.455.

11 (5) “Health equity” has the meaning prescribed by the Oregon Health
12 Policy Board and adopted by the authority by rule.

13 (6)(a) “Material change transaction” means:

14 (A) A transaction in which at least one party had average revenue of \$25
15 million or more in the preceding three fiscal years and another party:

16 (i) Had an average revenue of at least \$10 million in the preceding three
17 fiscal years; or

18 (ii) In the case of a new entity, is projected to have at least \$10 million
19 in revenue in the first full year of operation at normal levels of utilization
20 or operation as prescribed by the authority by rule.

21 (B) If a transaction involves a health care entity in this state and an
22 out-of-state entity, a transaction that otherwise qualifies as a material
23 change transaction under this paragraph that may result in increases in the
24 price of health care or limit access to health care services in this state.

25 (b) “Material change transaction” does not include:

26 (A) A clinical affiliation of health care entities formed for the purpose
27 of collaborating on clinical trials or graduate medical education programs.

28 (B) A medical services contract or an extension of a medical services
29 contract.

30 (C) An affiliation that:

31 (i) Does not impact the corporate leadership, governance or control of an

1 entity; and

2 (ii) Is necessary, as prescribed by the authority by rule, to adopt advanced
3 value-based payment methodologies to meet the health care cost growth tar-
4 gets under ORS 442.386.

5 (D) Contracts under which one health care entity, for and on behalf of a
6 second health care entity, provides patient care and services or provides ad-
7 ministrative services relating to, supporting or facilitating the provision of
8 patient care and services, if the second health care entity:

9 (i) Maintains responsibility, oversight and control over the patient care
10 and services; and

11 (ii) Bills and receives reimbursement for the patient care and services.

12 (E) Transactions in which a participant that is a health center as defined
13 in 42 U.S.C. 254b, while meeting all of the participant's obligations, acquires,
14 affiliates with, partners with or enters into any agreement with another en-
15 tity unless the transaction would result in the participant no longer quali-
16 fying as a health center under 42 U.S.C. 254b.

17 (7)(a) "Medical services contract" means a contract to provide medical
18 or mental health services entered into by:

19 (A) A carrier and an independent practice association;

20 (B) A carrier, coordinated care organization, independent practice asso-
21 ciation or network of providers and one or more providers, as defined in ORS
22 743B.001;

23 (C) An independent practice association and an individual health profes-
24 sional or an organization of health care providers;

25 (D) Medical, dental, vision or mental health clinics; or

26 (E) A medical, dental, vision or mental health clinic and an individual
27 health professional to provide medical, dental, vision or mental health ser-
28 vices.

29 (b) "Medical services contract" does not include a contract of employment
30 or a contract creating a legal entity and ownership of the legal entity that
31 is authorized under ORS chapter 58, 60 or 70 or under any other law au-

1 authorizing the creation of a professional organization similar to those au-
2 thorized by ORS chapter 58, 60 or 70, as may be prescribed by the authority
3 by rule.

4 (8) "Net patient revenue" means the total amount of revenue, after al-
5 lowance for contractual amounts, charity care and bad debt, received for
6 patient care and services, including:

7 (a) Value-based payments;

8 (b) Incentive payments;

9 (c) Capitation payments or payments under any similar contractual ar-
10 rangement for the prepayment or reimbursement of patient care and services;
11 and

12 (d) Any payment received by a hospital to reimburse a hospital assessment
13 under ORS 414.855.

14 (9) "Revenue" means:

15 (a) Net patient revenue; or

16 (b) The gross amount of premiums received by a health care entity that
17 are derived from health benefit plans.

18 (10) "Transaction" means:

19 (a) A merger of a health care entity with another entity;

20 (b) An acquisition of one or more health care entities by another entity;

21 (c) New contracts, new clinical affiliations and new contracting affil-
22 iations that will eliminate or significantly reduce, as defined by the author-
23 ity by rule, essential services;

24 (d) A corporate affiliation involving at least one health care entity; or

25 (e) Transactions to form a new partnership, joint venture, accountable
26 care organization, parent organization or management services organization,
27 as prescribed by the authority by rule.

28 **SECTION 25.** ORS 416.510 is amended to read:

29 416.510. As used in ORS 416.510 to 416.610, unless the context requires
30 otherwise:

31 (1) "Action" means an action, suit or proceeding.

1 (2) “Alternative payment methodology” has the meaning given that term
2 in ORS 414.025.

3 (3) “Applicant” means an applicant for assistance.

4 (4) “Assistance” means moneys paid by the Department of Human Services
5 to persons directly and moneys paid by the Oregon Health Authority [*or by*
6 *a prepaid managed care health services organization*] or **by** a coordinated care
7 organization for services provided under contract pursuant to ORS 414.591
8 to others for the benefit of such persons.

9 (5) “Authority” means the Oregon Health Authority.

10 (6) “Claim” means a claim of a recipient of assistance for damages for
11 personal injuries against any person or public body, agency or commission
12 other than the State Accident Insurance Fund Corporation or Workers’
13 Compensation Board.

14 (7) “Compromise” means a compromise between a recipient and any per-
15 son or public body, agency or commission against whom the recipient has a
16 claim.

17 (8) “Coordinated care organization” means an organization that meets the
18 criteria adopted by the authority under ORS 414.572.

19 (9) “Judgment” means a judgment in any action or proceeding brought
20 by a recipient to enforce the claim of the recipient.

21 [(10) “Prepaid managed care health services organization” has the meaning
22 given that term in ORS 414.025.]

23 [(11)] (10) “Recipient” means a recipient of assistance.

24 [(12)] (11) “Settlement” means a settlement between a recipient and any
25 person or public body, agency or commission against whom the recipient has
26 a claim.

27 **SECTION 26.** ORS 416.540 is amended to read:

28 416.540. (1) Except as provided in subsection (2) of this section and in ORS
29 416.590, the Department of Human Services and the Oregon Health Authority
30 shall have a lien upon the amount of any judgment in favor of a recipient
31 or amount payable to the recipient under a settlement or compromise for all

1 assistance received by such recipient from the date of the injury of the re-
2 cipient to the date of satisfaction of such judgment or payment under such
3 settlement or compromise.

4 (2) The lien does not attach to the amount of any judgment, settlement
5 or compromise to the extent of attorney's fees, costs and expenses incurred
6 by a recipient in securing such judgment, settlement or compromise and to
7 the extent of medical, surgical and hospital expenses incurred by the recipi-
8 ent on account of the personal injuries for which the recipient had a claim.

9 (3) The authority may assign the lien described in subsection (1) of this
10 section to a [*prepaid managed care health services organization or a*] coordi-
11 nated care organization for medical costs incurred by a recipient:

12 (a) During a period for which the authority paid a capitation or enroll-
13 ment fee or a payment using a global payment methodology; and

14 (b) On account of the personal injury for which the recipient had a claim.

15 (4) A [*prepaid managed care health services organization or a*] coordinated
16 care organization to which the authority has assigned a lien shall notify the
17 authority no later than 10 days after filing notice of a lien.

18 (5) For the purposes of ORS 416.510 to 416.610, the authority may desig-
19 nate the [*prepaid managed care health services organization or the*] coordi-
20 nated care organization to which a lien is assigned as its designee.

21 (6) If the authority and a [*prepaid managed care health services organiza-*
22 *tion or a*] coordinated care organization both have filed a lien, the
23 authority's lien shall be satisfied first.

24 **SECTION 27.** ORS 646.639 is amended to read:

25 646.639. (1) As used in this section and ORS 646A.670:

26 (a) "Charged-off debt" means a debt that a creditor treats as a loss or
27 expense and not as an asset.

28 (b) "Consumer" means a natural person who purchases or acquires prop-
29 erty, services or credit for personal, family or household purposes.

30 (c) "Consumer transaction" means a transaction between a consumer and
31 a person that sells, leases or provides property, services or credit to con-

1 sumers.

2 (d) "Credit" means a right that a creditor grants to a consumer to defer
3 payment of a debt, to incur a debt and defer payment of the debt, or to
4 purchase or acquire property or services and defer payment for the property
5 or services.

6 (e) "Creditor" means a person that, in the ordinary course of the person's
7 business, engages in consumer transactions that result in a consumer owing
8 a debt to the person.

9 (f) "Debt" means an obligation or alleged obligation that arises out of a
10 consumer transaction.

11 (g)(A) "Debt buyer" means a person that regularly engages in the business
12 of purchasing charged-off debt for the purpose of collecting the charged-off
13 debt or hiring another person to collect or bring legal action to collect the
14 charged-off debt.

15 (B) "Debt buyer" does not include a person that acquires charged-off debt
16 as an incidental part of acquiring a portfolio of debt that is predominantly
17 not charged-off debt.

18 (h) "Debt collector" means a person that by direct or indirect action,
19 conduct or practice collects or attempts to collect a debt owed, or alleged
20 to be owed, to a creditor or debt buyer.

21 (i) "Debtor" means a consumer who owes or allegedly owes a debt, in-
22 cluding a consumer who owes an amount that differs from the amount that
23 a debt collector attempts to collect or that a debt buyer purchased or at-
24 tempts to collect.

25 (j) "Legal action" means a lawsuit, mediation, arbitration or any other
26 proceeding in any court, including a small claims court.

27 (k) "Original creditor" means the last entity that extended credit to a
28 consumer to purchase goods or services, to lease goods or as a loan of mon-
29 eys.

30 (L) "Person" means an individual, corporation, trust, partnership, incor-
31 porated or unincorporated association or any other legal entity.

1 (2) A debt collector engages in an unlawful collection practice if the debt
2 collector, while collecting or attempting to collect a debt, does any of the
3 following:

4 (a) Uses or threatens to use force or violence to cause physical harm to
5 a debtor or to the debtor's family or property.

6 (b) Threatens arrest or criminal prosecution.

7 (c) Threatens to seize, attach or sell a debtor's property if doing so re-
8 quires a court order and the debt collector does not disclose that seizing,
9 attaching or selling the debtor's property requires prior court proceedings.

10 (d) Uses profane, obscene or abusive language in communicating with a
11 debtor or the debtor's family.

12 (e) Communicates with a debtor or any member of the debtor's family
13 repeatedly or continuously or at times known to be inconvenient to the
14 debtor or any member of the debtor's family and with intent to harass or
15 annoy the debtor or any member of the debtor's family.

16 (f) Communicates or threatens to communicate with a debtor's employer
17 concerning the nature or existence of the debt.

18 (g) Communicates without a debtor's permission or threatens to commu-
19 nicate with the debtor at the debtor's place of employment if the place of
20 employment is other than the debtor's residence, except that the debt col-
21 lector may:

22 (A) Write to the debtor at the debtor's place of employment if a home
23 address is not reasonably available and if the envelope does not reveal that
24 the communication is from a debt collector other than the person that pro-
25 vided the goods, services or credit from which the debt arose.

26 (B) Telephone a debtor's place of employment without informing any
27 other person of the nature of the call or identifying the caller as a debt
28 collector but only if the debt collector in good faith has made an unsuc-
29 cessful attempt to telephone the debtor at the debtor's residence during the
30 day or during the evening between the hours of 6 p.m. and 9 p.m. The debt
31 collector may not contact the debtor at the debtor's place of employment

1 more frequently than once each business week and may not telephone the
2 debtor at the debtor's place of employment if the debtor notifies the debt
3 collector not to telephone at the debtor's place of employment or if the debt
4 collector knows or has reason to know that the debtor's employer prohibits
5 the debtor from receiving such communication. For the purposes of this
6 subparagraph, any language in any agreement, contract or instrument that
7 creates or is evidence of the debt and that purports to authorize telephone
8 calls at the debtor's place of employment does not give permission to the debt
9 collector to call the debtor at the debtor's place of employment.

10 (h) Communicates with a debtor in writing without clearly identifying the
11 name of the debt collector, the name of the person, if any, for whom the debt
12 collector is attempting to collect the debt and the debt collector's business
13 address, on all initial communications. In subsequent communications in-
14 volving multiple accounts, the debt collector may eliminate the name of the
15 person, if any, for whom the debt collector is attempting to collect the debt
16 and substitute the term "various" in place of the person's name.

17 (i) Communicates with a debtor orally without disclosing to the debtor,
18 within 30 seconds after beginning the communication, the name of the indi-
19 vidual who is initiating the communication and the true purpose of the
20 communication.

21 (j) Conceals the true purpose of the communication so as to cause any
22 expense to a debtor in the form of long distance telephone calls, telegram
23 fees, additional charges for wireless communication or other charges the
24 debtor might incur by using a medium of communication.

25 (k) Attempts or threatens to enforce a right or remedy while knowing or
26 having reason to know that the right or remedy does not exist, or threatens
27 to take any action that the debt collector in the regular course of business
28 does not take.

29 (L) Uses any form of communication that simulates legal or judicial pro-
30 cess or that appears to be authorized, issued or approved by a governmental
31 agency, governmental official or an attorney at law if the corresponding

1 governmental agency, governmental official or attorney at law has not in
2 fact authorized or approved the communication.

3 (m) Represents that an existing debt may be increased by the addition of
4 attorney fees, investigation fees or any other fees or charges if the fees or
5 charges may not legally be added to the existing debt.

6 (n) Collects or attempts to collect interest or other charges or fees that
7 exceed the actual debt unless the agreement, contract or instrument that
8 creates the debt expressly authorizes, or a law expressly allows, the interest
9 or other charges or fees.

10 (o) Threatens to assign or sell a debtor's account and misrepresents or
11 implies that the debtor would lose any defense to the debt or would be sub-
12 jected to harsh, vindictive or abusive collection tactics.

13 (p) Uses the seal or letterhead of a public official or a public agency, as
14 those terms are defined in ORS 171.725.

15 (q) Collects or attempts to collect any debt that the debt collector knows,
16 or after exercising reasonable diligence would know, arises from medical
17 expenses that qualify for reimbursement under the Oregon Health Plan or
18 under Medicaid, except that:

19 (A) The debt collector does not engage in an unlawful collection practice
20 if the debt collector can produce an affidavit or certificate from the original
21 creditor that shows that the original creditor complied with Oregon Health
22 Authority rules barring payments for services that Medicaid fee-for-service
23 plans or contracted health care plans cover; and

24 (B) For purposes of this paragraph, [*a prepaid managed care health ser-*
25 *vices organization,*] a coordinated care organization or a public body, as de-
26 fined in ORS 174.109, or an agent or assignee of the organization or public
27 body, is not a debt collector if the organization or public body seeks to col-
28 lect a debt that arises under ORS 416.540.

29 (r) Files a legal action to collect or files a legal action to attempt to
30 collect a debt if the debt collector knows, or after exercising reasonable
31 diligence would know, that an applicable statute of limitations bars the col-

1 lection or the collection attempt.

2 (s) Knowingly collects any amount, including any interest fee, charge or
3 expense incidental to the principal obligation, unless the amount is expressly
4 authorized by the agreement creating the debt or permitted by law.

5 (t) Collects or attempts to collect a debt if the debt collector is a debt
6 buyer, or is acting on a debt buyer's behalf, and collects or attempts to col-
7 lect purchased debt before providing to a debtor, within 30 days after the
8 date of the debtor's request, all of the documents listed in subsection (4)(b)
9 of this section.

10 (u) Collects or attempts to collect a debt without complying with the re-
11 quirements of ORS 646A.677.

12 (3) A debt collector engages in an unlawful collection practice if the debt
13 collector, by use of any direct or indirect action, conduct or practice, en-
14 forces or attempts to enforce an obligation made void and unenforceable by
15 the provisions of ORS 759.720 (3) to (5).

16 (4) A debt buyer or debt collector acting on behalf of a debt buyer engages
17 in an unlawful collection practice if the debt buyer or debt collector:

18 (a) Files legal action against a debtor or files legal action to attempt to
19 collect a debt if the debt buyer or debt collector knows or after exercising
20 reasonable diligence would know that an applicable statute of limitations
21 bars the legal action to collect or the legal action to attempt to collect the
22 debt;

23 (b) Brings a legal action against a debtor or otherwise brings a legal
24 action to attempt to collect a debt without possessing business records that
25 satisfy the requirements of ORS 40.460 (6), or of ORS 24.115, if the record is
26 a foreign judgment, that establish the nature and the amount of the debt and
27 that include:

28 (A) The original creditor's name, written as the original creditor used the
29 name in dealings with the debtor;

30 (B) The name and address of the debtor;

31 (C) The name, address and telephone number of the person that owns the

1 debt and a statement as to whether the person is a debt buyer;

2 (D) The last four digits of the original creditor's account number for the
3 debt, if the original creditor's account number for the debt had four or more
4 digits;

5 (E) A detailed and itemized statement of:

6 (i) The amount the debtor last paid on the debt, if the debtor made a
7 payment, and the date of the payment;

8 (ii) The amount and date of the debtor's last payment on the debt before
9 the debtor defaulted or before the debt became charged-off debt;

10 (iii) The balance due on the debt on the date on which the debt became
11 charged-off debt;

12 (iv) The amount and rate of interest, any fees and any charges that the
13 original creditor imposed, if the debt buyer or debt collector knows the
14 amount, rate, fee or charge;

15 (v) The amount and rate of interest, any fees and any charges that the
16 debt buyer or any previous owner of the debt imposed, if the debt buyer or
17 debt collector knows the amount, rate, fee or charge;

18 (vi) The attorney fees the debt buyer or debt collector seeks, if the debt
19 buyer or debt collector expects to recover attorney fees; and

20 (vii) Any other fee, cost or charge the debt buyer seeks to recover;

21 (F) Evidence that the debt buyer and only the debt buyer owns the debt;

22 (G) The date on which the debt buyer purchased the debt; and

23 (H) A copy of the agreement between the original creditor and the debtor
24 that is either:

25 (i) The contract or other writing the debtor signed that created and is
26 evidence of the original debt; or

27 (ii) A copy of the most recent monthly statement that shows a purchase
28 transaction or balance transfer or the debtor's last payment, if the debtor
29 made a payment, if the debt is a credit card debt or other debt for which a
30 contract or other writing that is evidence of the debt does not exist;

31 (c) Fails to provide to a debtor, after the debt buyer or debt collector

1 receives payment in cash or the debtor requests the receipt, a receipt that:

2 (A) Shows the name of the creditor or creditors for whom the debt buyer
3 or debt collector received the payment and, if the creditor is not the original
4 creditor, the account number that the original creditor assigned; and

5 (B) States clearly whether the debt buyer or debt collector accepts the
6 payment as payment in full or as a full and final compromise of the debt and,
7 if not, the balance remaining on the debt after the payment;

8 (d) Collects or attempts to collect a debt before providing, in response to
9 a debtor's request, the documents required under paragraph (b) of this sub-
10 section. A debt buyer or a debt collector that acts on the debt buyer's behalf
11 does not engage in an unlawful collection practice under this paragraph if
12 the debt buyer or debt collector collects or attempts to collect a debt after
13 providing the required documents to the debtor; or

14 (e) Uses any direct or indirect action, conduct or practice to violate a
15 provision of this section or ORS 646A.670.

16 (5) A debt collector is not acting on a debt buyer's behalf, and is not
17 subject to the duties to which a debt buyer is subject under this section and
18 ORS 646A.670, if the debt collector collects or attempts to collect a debt on
19 behalf of an owner that retains a direct interest in the debt or if the debt
20 is not a debt that a debt buyer purchased.

21 **SECTION 28.** ORS 679.540 is amended to read:

22 679.540. (1) As used in this section:

23 (a) "Dental provider" means a licensed dentist, dental hygienist or other
24 dental practitioner or a dental care team or clinic that provides the follow-
25 ing core services:

26 (A) Comprehensive dental care;

27 (B) Basic preventive dental services;

28 (C) Referral to dental specialists; and

29 (D) Family centered dental care.

30 (b) "Health worker" means "traditional health worker" as defined by the
31 Oregon Health Authority by rule.

1 (2) The Oregon Health Authority, in consultation with coordinated care
2 organizations [*and dental care organizations*] in this state, shall adopt rules
3 and procedures for the training and certification of health workers to pro-
4 vide oral disease prevention services and for the reimbursement of oral dis-
5 ease prevention services provided by certified health workers.

6 (3) The rules adopted under subsection (2) of this section must prescribe
7 the training required for certification, including instruction on:

8 (a) The performance of dental risk assessments; and

9 (b) The provision of oral disease prevention services.

10 (4) The authority shall adopt rules requiring that a certified health
11 worker:

12 (a) Refer patients to dental providers; and

13 (b) Recommend to patients, or to the parent or legal guardian of a patient,
14 that the patient visit a dental provider at least once annually.

15 **SECTION 29.** ORS 741.300 is amended to read:

16 741.300. As used in ORS 741.001 to 741.540:

17 (1) “Coordinated care organization” has the meaning given that term in
18 ORS 414.025.

19 (2) “Essential health benefits” has the meaning given that term in ORS
20 731.097.

21 (3) “Health benefit plan” has the meaning given that term in ORS
22 743B.005.

23 (4) “Health care service contractor” has the meaning given that term in
24 ORS 750.005.

25 (5) “Health insurance” has the meaning given that term in ORS 731.162,
26 excluding disability income insurance.

27 (6) “Health insurance exchange” or “exchange” means the division of the
28 Oregon Health Authority that operates an American Health Benefit Ex-
29 change as described in 42 U.S.C. 18031, 18032, 18033 and 18041.

30 (7) “Health plan” means a health benefit plan or dental only benefit plan
31 offered by an insurer.

1 (8) “Insurer” means an insurer as defined in ORS 731.106 that offers
2 health insurance, a health care service contractor[, *a prepaid managed care*
3 *health services organization*] or a coordinated care organization.

4 (9) “Insurance producer” has the meaning given that term in ORS 731.104.

5 [(10) “Prepaid managed care health services organization” has the meaning
6 given that term in ORS 414.025.]

7 [(11)] (10) “State program” means a program providing medical assistance,
8 as defined in ORS 414.025, and any self-insured health benefit plan or health
9 plan offered to employees by the Public Employees’ Benefit Board or the
10 Oregon Educators Benefit Board.

11 [(12)] (11) “Qualified health plan” means a health benefit plan certified
12 by the authority in accordance with the requirements, standards and criteria
13 adopted by the authority under ORS 741.310.

14 [(13)] (12) “Small Business Health Options Program” or “SHOP” means
15 a health insurance exchange for small employers as described in 42 U.S.C.
16 18031.

17 **SECTION 30.** ORS 743.029 is amended to read:

18 743.029. (1) The Department of Consumer and Business Services may adopt
19 by rule uniform standards applicable to persons listed in subsection (2) of
20 this section for health care financial and administrative transactions, in-
21 cluding uniform standards for:

- 22 (a) Eligibility inquiry and response;
- 23 (b) Claim submission;
- 24 (c) Payment remittance advice;
- 25 (d) Claims payment or electronic funds transfer;
- 26 (e) Claims status inquiry and response;
- 27 (f) Claims attachments;
- 28 (g) Prior authorization;
- 29 (h) Provider credentialing; or
- 30 (i) Health care financial and administrative transactions identified by the
31 stakeholder work group described in ORS 743.031.

1 (2) Any uniform standards adopted under subsection (1) of this section
2 apply to:

3 (a) Health insurers.

4 [(b) *Prepaid managed care health services organizations as defined in ORS*
5 *414.025.*]

6 [(c)] (b) Coordinated care organizations as defined in ORS 414.025.

7 [(d)] (c) Third party administrators.

8 [(e)] (d) Any person or public body that either individually or jointly es-
9 tablishes a self-insurance plan, program or contract, including but not lim-
10 ited to persons and public bodies that are otherwise exempt from the
11 Insurance Code under ORS 731.036.

12 [(f)] (e) Health care clearinghouses or other entities that process or fa-
13 cilitate the processing of health care financial and administrative trans-
14 actions from a nonstandard format to a standard format.

15 [(g)] (f) Any other person identified by the department that processes
16 health care financial and administrative transactions between a health care
17 provider and an entity described in this subsection.

18 (3) In developing or updating any uniform standards adopted under sub-
19 section (1) of this section, the department shall consider recommendations
20 from the Oregon Health Authority under ORS 743.031.

21 **SECTION 31.** Section 1, chapter 61, Oregon Laws 2022, is amended to
22 read:

23 **Sec. 1.** (1) As used in this section:

24 [(a) *“Dental care organization” means a prepaid managed care health ser-*
25 *vices organization, as defined in ORS 414.025, that provides dental care to*
26 *members of a coordinated care organization.*]

27 (a) **“Coordinated care organization” has the meaning given that**
28 **term in ORS 414.025.**

29 (b) “Medical assistance” has the meaning given that term in ORS 414.025.

30 (c) “Veteran” means an individual who is a veteran, as defined in ORS
31 408.225, except the individual may be discharged or released under honorable

1 or other than honorable conditions.

2 (2) The Veterans Dental Program is established in the Oregon Health
3 Authority and shall be administered in collaboration with the Department
4 of Consumer and Business Services. The purpose of the program is to provide
5 oral health care to eligible veterans who are residing in Oregon.

6 (3) The authority shall contract with [*dental*] **coordinated** care organ-
7 izations throughout this state and with individual oral health care providers
8 in areas of this state that are not served by [*dental*] **coordinated** care or-
9 ganizations to provide oral health care to veterans enrolled in the Veterans
10 Dental Program.

11 (4) Enrollees in the Veterans Dental Program shall receive the types and
12 extent of oral health care services that the authority determines will be
13 provided to medical assistance recipients in accordance with ORS 414.065,
14 without any corresponding copayments, deductibles or cost sharing required.

15 (5) An individual is eligible for the Veterans Dental Program if the indi-
16 vidual:

17 (a) Is a resident of Oregon;

18 (b) Is ineligible for medical assistance;

19 (c) Has income that is at or below 400 percent of the federal poverty
20 guidelines; and

21 (d) Is a veteran.

22 (6) The authority shall:

23 (a) Prescribe by rule a simple application process for the Veterans Dental
24 Program.

25 (b) Provide assistance, in person or by telephone, to applicants for and
26 enrollees in the program.

27 (c) Require and accept as verification of eligibility:

28 (A) Documentation demonstrating that an applicant's income is at or be-
29 low 400 percent of the federal poverty guidelines.

30 (B) An applicant's federal DD Form 214 or 215.

31 **SECTION 32.** Section 1, chapter 87, Oregon Laws 2022, is amended to

1 read:

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

3 (a) “COFA citizen” has the meaning given that term in ORS 413.611.

4 *[(b) “Dental care organization” means a prepaid managed care health ser-*
5 *vices organization, as defined in ORS 414.025, that provides dental care to*
6 *members of a coordinated care organization.]*

7 **(b) “Coordinated care organization” has the meaning given that**
8 **term in ORS 414.025.**

9 (c) “Income” means the modified adjusted gross income that is attributed
10 to an individual in determining the individual’s eligibility for the medical
11 assistance program.

12 (2) The COFA Dental Program is established in the Oregon Health Au-
13 thority. The purpose of the program is to provide oral health care to low-
14 income citizens of the island nations in the Compact of Free Association who
15 are residing in Oregon.

16 (3) The authority shall contract with [*dental*] **coordinated** care organ-
17 izations throughout this state, and with individual oral health care providers
18 in areas of this state that are not served by [*dental*] **coordinated** care or-
19 ganizations, to provide oral health care to COFA citizens enrolled in the
20 COFA Dental Program.

21 (4) Enrollees in the COFA Dental Program shall receive the types and
22 extent of oral health care services that the authority determines will be
23 provided to medical assistance recipients in accordance with ORS 414.065,
24 without any corresponding copayments, deductibles or cost sharing required.

25 (5) An individual is eligible for the COFA Dental Program if the indi-
26 vidual:

27 (a) Is a resident of Oregon;

28 (b) Is a COFA citizen;

29 (c) Has income that is less than 138 percent of the federal poverty
30 guidelines; and

31 (d) Does not qualify for Medicaid under Title XIX of the Social Security

1 Act or the Children's Health Insurance Program under Title XXI of the So-
2 cial Security Act.

3 (6) The authority may use the application process described in ORS
4 411.400 for the COFA Dental Program. The authority shall provide culturally
5 and linguistically appropriate assistance, in person and by telephone, to ap-
6 plicants for and enrollees in the program. The application process, forms and
7 notices used in the COFA Dental Program must conform to the guidance
8 adopted by the United States Department of Health and Human Services, in
9 accordance with Title VI of the Civil Rights Act of 1964, regarding the pro-
10 hibition against national origin discrimination affecting persons with limited
11 English proficiency in federally funded programs.

12 (7) The authority shall accept as verification of eligibility the attestation
13 of an applicant for or enrollee in the COFA Dental Program that the appli-
14 cant or enrollee meets the requirements of subsection (5) of this section.

15 (8) The authority shall conduct outreach as described in ORS 413.612
16 (4)(e) to facilitate applications for and enrollment in the COFA Dental Pro-
17 gram.

18 (9) The authority may not disclose personally identifying information
19 about applicants for or enrollees in the COFA Dental Program except to the
20 extent necessary to conduct outreach under subsection (8) of this section or
21 to comply with federal or state laws.

22 **SECTION 33.** ORS 413.181 is amended to read:

23 413.181. (1) The Department of Consumer and Business Services and the
24 Oregon Health Authority may enter into agreements governing the disclo-
25 sure of information reported to the department by insurers with certificates
26 of authority to transact insurance in this state and the disclosure of infor-
27 mation reported to the Oregon Health Authority by coordinated care organ-
28 izations.

29 (2) The authority may use information disclosed under subsection (1) of
30 this section for the purpose of carrying out ORS 413.032, 414.572, 414.591,
31 414.605, 414.609, [414.638,] 415.012 to 415.430 and 415.501.

1 **SECTION 34.** ORS 414.607 is amended to read:

2 414.607. (1) The Oregon Health Authority shall ensure the appropriate use
3 of member information by coordinated care organizations, including the use
4 of electronic health information and administrative data that is available
5 when and where the data is needed to improve health and health care
6 through a secure, confidential health information exchange.

7 (2) A member of a coordinated care organization must have access to the
8 member's personal health information in the manner provided in 45 C.F.R.
9 164.524 so the member can share the information with others involved in the
10 member's care and make better health care and lifestyle choices.

11 (3) Notwithstanding ORS 179.505, a coordinated care organization, its
12 provider network and programs administered by the Department of Human
13 Services for seniors and persons with disabilities shall use and disclose
14 member information for purposes of service and care delivery, coordination,
15 service planning, transitional services and reimbursement, in order to im-
16 prove the safety and quality of care, lower the cost of care and improve the
17 health and well-being of the organization's members.

18 (4) A coordinated care organization and its provider network shall use
19 and disclose sensitive diagnosis information including blood-borne infections
20 and other health and mental health diagnoses, within the coordinated care
21 organization for the purpose of providing whole-person care. Individually
22 identifiable health information must be treated as confidential and privileged
23 information subject to ORS 192.553 to 192.581 and applicable federal privacy
24 requirements. Redisclosure of individually identifiable information outside
25 of the coordinated care organization and the organization's providers for
26 purposes unrelated to this section or the requirements of ORS 413.032,
27 414.572, 414.598, 414.605, 414.632[, 414.638] or 414.655 remains subject to any
28 applicable federal or state privacy requirements.

29 (5) This section does not prohibit the disclosure of information between
30 a coordinated care organization and the organization's provider network, and
31 the Oregon Health Authority and the Department of Human Services for the

1 purpose of administering the laws of Oregon.

2 (6) The Health Information Technology Oversight Council shall develop
3 readily available informational materials that can be used by coordinated
4 care organizations and providers to inform all participants in the health care
5 workforce about the appropriate uses and limitations on disclosure of elec-
6 tronic health records, including need-based access and privacy mandates.

7 **SECTION 35.** ORS 414.882 is amended to read:

8 414.882. (1) A [*managed*] **coordinated** care organization that has paid an
9 amount that is not required under ORS 414.880 may file a claim for refund
10 with the Oregon Health Authority.

11 (2) Any [*managed*] **coordinated** care organization that is aggrieved by an
12 action of the authority taken pursuant to subsection (1) of this section shall
13 be entitled to notice and an opportunity for a contested case hearing under
14 ORS chapter 183.

15 **SECTION 36.** ORS 414.884 is amended to read:

16 414.884. ORS 414.880, 414.882 and 414.902 apply to any payments made to
17 a [*managed*] **coordinated** care organization by the Oregon Health Authority
18 for the period beginning January 1, 2020, and ending December 31, 2026.

19

20

REPEALS

21

22 **SECTION 37.** (1) ORS 414.638 is repealed on January 2, 2025.

23 (2) ORS 414.654 is repealed.

24

25

APPLICABILITY

26

27 **SECTION 38.** Notwithstanding the amendments to ORS 413.017 and
28 414.025 by sections 3, 5 and 6 of this 2023 Act and the repeal of ORS
29 414.638 by section 37 of this 2023 Act, the metrics and scoring sub-
30 committee created in ORS 414.638 shall select the quality measures
31 that apply to coordinated care organization contracts in the calendar

1 years up to and including the calendar year in which the Health Equity
2 Quality Metrics Committee establishes quality measures.

3

4

CAPTIONS

5

6 SECTION 39. The unit captions used in this 2023 Act are provided
7 only for the convenience of the reader and do not become part of the
8 statutory law of this state or express any legislative intent in the
9 enactment of this 2023 Act.

10

11

EMERGENCY CLAUSE

12

13 SECTION 40. This 2023 Act being necessary for the immediate
14 preservation of the public peace, health and safety, an emergency is
15 declared to exist, and this 2023 Act takes effect on its passage.

16
