

Senate Bill 690

Sponsored by Senator MANNING JR (at the request of Charlie Swanson) (Pre-session filed.)

SUMMARY

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

Creates Community Escrow Fund in State Treasury to hold coordinated care organization restricted reserves. Allows coordinated care organization to request from Oregon Health Authority payments from fund in amounts needed to pay costs not accounted for in establishing coordinated care organization's global budget.

A BILL FOR AN ACT

1
2 Relating to coordinated care organization reserves; creating new provisions; and amending ORS
3 414.572, 414.591, 415.011, 415.056, 415.115 and 415.204, and section 2, chapter 467, Oregon Laws
4 2021.

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

6 **SECTION 1. (1) The Community Escrow Fund is established in the State Treasury, sep-**
7 **arate and distinct from the General Fund, consisting of moneys allocated to the Community**
8 **Escrow Fund by the Oregon Health Authority in accordance with section 3 of this 2023 Act.**
9 **Interest earned by the Community Escrow Fund shall be credited to the fund. Moneys in the**
10 **Community Escrow Fund are continuously appropriated to the Oregon Health Authority for**
11 **the purposes described in section 2 of this 2023 Act.**

12 **(2) Each coordinated care organization that contracts with the authority shall have a**
13 **designated subaccount within the Community Escrow Fund.**

14 **SECTION 2. The Oregon Health Authority shall adopt by rule criteria for the amount of**
15 **and eligibility for a payment of moneys from the Community Escrow Fund in order to pay**
16 **costs not accounted for in establishing a coordinated care organization's global budget. A**
17 **coordinated care organization seeking moneys from the fund shall make an application to the**
18 **authority in a form and manner prescribed by the authority. Upon finding that the coordi-**
19 **nated care organization meets the criteria adopted under this section, the authority shall**
20 **make a payment to the coordinated care organization from the subaccount designated for**
21 **the coordinated care organization under section 3 of this 2023 Act.**

22 **SECTION 3. The Oregon Health Authority shall withhold an amount from each global**
23 **budget payment made to a coordinated care organization. The amount withheld shall be paid**
24 **into a subaccount designated for the coordinated care organization within the Community**
25 **Escrow Fund established under section 1 of this 2023 Act. The amount withheld shall be**
26 **calculated to achieve, by January 1, 2029, an amount equal to the restricted reserves required**
27 **for the coordinated care organization under ORS 414.572 (1)(b)(A).**

28 **SECTION 4. Notwithstanding ORS 414.572 (1)(b)(A), a coordinated care organization may**
29 **expend its restricted reserves for operating expenses up to the total amount withheld from**
30 **the coordinated care organization by the authority under section 3 of this 2023 Act.**

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

5 414.572. (1) The Oregon Health Authority shall adopt by rule the qualification criteria and re-
6 quirements for a coordinated care organization and shall integrate the criteria and requirements
7 into each contract with a coordinated care organization. Coordinated care organizations may be
8 local, community-based organizations or statewide organizations with community-based participation
9 in governance or any combination of the two. Coordinated care organizations may contract with
10 counties or with other public or private entities to provide services to members. The authority may
11 not contract with only one statewide organization. A coordinated care organization may be a single
12 corporate structure or a network of providers organized through contractual relationships. The cri-
13 teria and requirements adopted by the authority under this section must include, but are not limited
14 to, a requirement that the coordinated care organization:

15 (a) Have demonstrated experience and a capacity for managing financial risk and establishing
16 financial reserves.

17 (b) Meet the following minimum financial requirements:

18 [(A) *Maintain restricted reserves of \$250,000 plus an amount equal to 50 percent of the coordinated*
19 *care organization's total actual or projected liabilities above \$250,000.*]

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

23 [(C)] (B) Expend a portion of the annual net income [*or reserves*] of the coordinated care or-
24 ganization that [*exceed*] **exceeds** the financial requirements specified in this paragraph on services
25 designed to address health disparities and the social determinants of health consistent with the co-
26 ordinated care organization's community health improvement plan and transformation plan and the
27 terms and conditions of the Medicaid demonstration project under section 1115 of the Social Secu-
28 rity Act (42 U.S.C. 1315).

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

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

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

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

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

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

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

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

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

9 (e) Members are provided:

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

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

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

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

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

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

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

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

29 (j) Each coordinated care organization prioritizes working with members who have high health
30 care needs, multiple chronic conditions or behavioral health conditions and involves those members
31 in accessing and managing appropriate preventive, health, remedial and supportive care and ser-
32 vices, including the services described in ORS 414.766, to reduce the use of avoidable emergency
33 room visits and hospital admissions.

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

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

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

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

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

43 (E) Include providers of specialty care.

44 (F) Are selected by coordinated care organizations using universal application and credentialing
45 procedures and objective quality information and are removed if the providers fail to meet objective

1 quality standards.

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

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

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

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

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

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

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

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

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

19 (i) A physician licensed under ORS chapter 677 or a nurse practitioner licensed under ORS
 20 678.375, whose area of practice is primary care; and

21 (ii) A behavioral health provider;

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

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

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

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

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

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

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

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

44 (D) Be available for training by the office within the authority that is responsible for tribal af-
 45 fairs, any federally recognized tribe in Oregon and the urban Indian health program that is located

1 within the area served by the coordinated care organization and operated by an urban Indian or-
2 ganization pursuant to 25 U.S.C. 1651.

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

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

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

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

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

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

14 **SECTION 6.** Section 2, chapter 467, Oregon Laws 2021, as amended by section 3, chapter 467,
15 Oregon Laws 2021, is amended to read:

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

18 (2) The authority shall:

19 (a) Require a coordinated care organization to spend no less than three percent of its global
20 budget on investments:

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

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

25 (iii) In efforts to diversify care locations; or

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

27 (B) That enhance payments to:

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

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

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

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

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

41 (A) Improve the behavioral health of members;

42 (B) Improve the behavioral health care delivery system in the community served by the coordi-
43 nated care organization;

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

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

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

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

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

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

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

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

18 (5) The authority shall:

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

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

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

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

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

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

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

36 414.591. (1) The Oregon Health Authority shall use, to the greatest extent possible, coordinated
 37 care organizations to provide fully integrated physical health services, chemical dependency and
 38 mental health services and oral health services. This section, and any contract entered into pur-
 39 suant to this section, does not affect and may not alter the delivery of Medicaid-funded long term
 40 care services.

41 (2) The authority shall execute contracts with coordinated care organizations that meet the
 42 criteria adopted by the authority under ORS 414.572. Contracts under this subsection are not subject
 43 to ORS chapters 279A and 279B, except ORS 279A.250 to 279A.290 and 279B.235.

44 (3)(a) The authority shall establish financial reporting requirements for coordinated care organ-
 45 izations, consistent with ORS 415.115 and 731.574, no less than 90 days before the beginning of the

1 reporting period. The authority shall prescribe requirements and procedures for financial reporting
2 that:

3 (A) Enable the authority to verify that the coordinated care organization's capital, surplus[, *re-*
4 *serves*] and other financial resources are adequate to ensure against the risk of insolvency;

5 (B) Include information on the three highest executive salary and benefit packages of each co-
6 ordinated care organization;

7 (C) Require quarterly reports to be filed with the authority by May 31, August 31 and November
8 30;

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

12 (E) Align, to the greatest extent practicable, with the National Association of Insurance
13 Commissioners' reporting forms to reduce the administrative costs of coordinated care organizations
14 that are also regulated by the Department of Consumer and Business Services or have affiliates that
15 are regulated by the department.

16 (b) The authority shall provide information to coordinated care organizations about the report-
17 ing standards of the National Association of Insurance Commissioners and provide training on the
18 reporting standards to the staff of coordinated care organizations who will be responsible for com-
19 piling the reports.

20 (4) The authority shall hold coordinated care organizations, contractors and providers account-
21 able for timely submission of outcome and quality data, including but not limited to data described
22 in ORS 442.373, prescribed by the authority by rule.

23 (5) The authority shall require compliance with the provisions of subsections (3) and (4) of this
24 section as a condition of entering into a contract with a coordinated care organization. A coordi-
25 nated care organization, contractor or provider that fails to comply with subsection (3) or (4) of this
26 section may be subject to sanctions, including but not limited to civil penalties, barring any new
27 enrollment in the coordinated care organization and termination of the contract.

28 (6)(a) The authority shall adopt rules and procedures to ensure that if a rural health clinic
29 provides a health service to a member of a coordinated care organization, and the rural health clinic
30 is not participating in the member's coordinated care organization, the rural health clinic receives
31 total aggregate payments from the member's coordinated care organization, other payers on the
32 claim and the authority that are no less than the amount the rural health clinic would receive in
33 the authority's fee-for-service payment system. The authority shall issue a payment to the rural
34 health clinic in accordance with this subsection within 45 days of receipt by the authority of a
35 completed billing form.

36 (b) "Rural health clinic," as used in this subsection, shall be defined by the authority by rule
37 and shall conform, as far as practicable or applicable in this state, to the definition of that term in
38 42 U.S.C. 1395x(aa)(2).

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

44 (8) The aggregate expenditures by the authority for health services provided pursuant to this
45 chapter may not exceed the total dollars appropriated for health services under this chapter.

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

6 (10) Health care providers contracting to provide services under this chapter shall advise a pa-
 7 tient of any service, treatment or test that is medically necessary but not covered under the con-
 8 tract if an ordinarily careful practitioner in the same or similar community would do so under the
 9 same or similar circumstances.

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

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

16 (13) Each coordinated care organization shall provide upon the request of a member or pro-
 17 spective member annual summaries of the organization's aggregate data regarding:

- 18 (a) Grievances and appeals; and
- 19 (b) Availability and accessibility of services provided to members.

20 (14) A coordinated care organization may not limit enrollment in a geographic area based on the
 21 zip code of a member or prospective member.

22 **SECTION 8.** ORS 415.011 is amended to read:

23 415.011. (1) The Oregon Health Authority may adopt rules to carry out the provisions of ORS
 24 415.012 to 415.430.

25 (2) The authority shall adopt rules for regulating the financial solvency of coordinated care or-
 26 ganizations that align with the following provisions of the Insurance Code regulating domestic
 27 insurers, to the extent the provisions regarding insurers are applicable to coordinated care organ-
 28 izations and are in accordance with ORS chapters 413 and 414:

- 29 (a) ORS 731.385;
- 30 (b) ORS 731.504;
- 31 (c) ORS 731.508;
- 32 (d) ORS 731.509 (1) to (10) and (12);
- 33 (e) ORS 731.574 (1) to (5);
- 34 (f) ORS 731.730;
- 35 (g) ORS 731.988;
- 36 (h) ORS 732.235;
- 37 (i) ORS 732.517 to 732.546, other than ORS 732.527, 732.531 and 732.541;
- 38 (j) ORS 732.548;
- 39 (k) ORS 732.549;
- 40 (L) ORS 732.551;
- 41 (m) ORS 732.552;
- 42 (n) ORS 732.553;
- 43 (o) ORS 732.554;
- 44 (p) ORS 732.556;
- 45 (q) ORS 732.558;

- 1 (r) ORS 732.564;
- 2 (s) ORS 732.566;
- 3 (t) ORS 732.567;
- 4 (u) ORS 732.568;
- 5 (v) ORS 732.569;
- 6 (w) ORS 732.574;
- 7 (x) ORS 732.576;
- 8 (y) ORS 732.578;
- 9 (z) ORS 732.592;
- 10 (aa) ORS 733.010 to 733.050;
- 11 (bb) ORS 733.140 to 733.170;
- 12 (cc) ORS 733.510 to 733.680;
- 13 (dd) ORS 733.695 to 733.780; and
- 14 (ee) ORS 734.014.

15 (3) Rules adopted by the authority in accordance with ORS 731.385 that establish minimum
 16 standards for risk-based capital may not require a coordinated care organization to take preventive
 17 or corrective measures to increase the coordinated care organization’s capital[,] **or** surplus [*or re-*
 18 *erves*] to achieve more than 200 percent of the minimum risk-based capital.

19 **SECTION 9.** ORS 415.056 is amended to read:

20 415.056. (1) The Oregon Health Authority may disclose or use a report as considered necessary
 21 by the authority in the administration of ORS 415.012 to 415.430, rules adopted pursuant to ORS
 22 415.011 or other law.

23 (2) A report filed with the authority according to requirements established by rule for disclosure
 24 of material acquisitions or dispositions of assets is confidential.

25 (3) A report filed with the Oregon Health Authority according to requirements established by
 26 rule for the purpose of determining the amount of [*restricted reserves*,] capital or surplus that a co-
 27 ordinated care organization must maintain under ORS 414.572 (1)(b)(A) is confidential and may not
 28 be disclosed.

29 (4) A financial plan of action stating corrective actions to be taken by a coordinated care or-
 30 ganization in response to a determination of inadequate [*restricted reserves*,] capital or surplus that
 31 is filed by the coordinated care organization with the authority according to requirements estab-
 32 lished by rule is confidential and may not be disclosed.

33 (5) The results or report of any examination or analysis of a coordinated care organization
 34 performed by the authority in connection with a financial plan described in subsection (4) of this
 35 section and any corrective order issued by the authority pursuant to such an examination or anal-
 36 ysis is confidential and may not be disclosed.

37 (6) Information contained in documents described in subsections (1) to (4) of this section that is
 38 also contained in final examination reports filed under ORS 415.111 is not confidential under this
 39 section.

40 (7) All financial analysis ratios and examination synopses concerning coordinated care organ-
 41 izations that are submitted to the authority by the Insurance Regulatory Information System of the
 42 National Association of Insurance Commissioners are confidential.

43 **SECTION 10.** ORS 415.115 is amended to read:

44 415.115. (1) A coordinated care organization shall have an annual audit conducted by an inde-
 45 pendent certified public accountant and shall file an audited financial report annually with the

1 Oregon Health Authority by June 30 following the end of the period to which the report applies.

2 The annual audited financial report shall disclose:

3 (a) The financial position of the coordinated care organization as of the end of the most recent
4 calendar year; and

5 (b) The results of the coordinated care organization's operations, cash flows and changes in
6 capital[,] **and** surplus [*and reserves*] for the year just ended.

7 (2) The authority shall adopt the following rules as needed for carrying out the requirements
8 of this section prescribing the:

9 (a) Required contents and format of the audited financial report.

10 (b) Requirements for filing the report.

11 (c) Requirements applicable to qualifications and designation of certified public accountants for
12 purposes of audits under this section, which may include limitations on length of service for certified
13 public accountants and may permit recognition of accountants comparably qualified under the laws
14 of another country.

15 (d) Requirements applicable to evaluation of the accounting procedures of a coordinated care
16 organization and its system of internal control by a certified public accountant.

17 (e) Standards governing the scope and preparation of the audit.

18 (f) Requirements and procedures relating to the reporting of the adverse financial condition of
19 a coordinated care organization by a certified public accountant.

20 (g) Requirements and procedures relating to the reporting of significant deficiencies for internal
21 controls of a coordinated care organization.

22 (h) Exemptions.

23 (i) Any other matter that the authority determines to be needed for preparation of or inclusion
24 in the financial report.

25 **SECTION 11.** ORS 415.204 is amended to read:

26 415.204. (1) For any reason stated in subsection (2) of this section, the Oregon Health Authority
27 may order a coordinated care organization to be placed under supervision.

28 (2) The authority may place a coordinated care organization under supervision if upon exam-
29 ination or at any other time the authority determines that:

30 (a) The condition of the coordinated care organization renders the continuance of its business
31 hazardous to the public or to its members.

32 (b) The coordinated care organization has refused to permit examination of its books, papers,
33 accounts, records or affairs by the authority or any deputy, examiner or employee representing the
34 authority.

35 (c) A coordinated care organization has unlawfully removed from this state books, papers, ac-
36 counts or records necessary for an examination of the coordinated care organization.

37 (d) The coordinated care organization has failed to comply promptly with the applicable finan-
38 cial reporting statutes or rules and any request of the authority relating to financial reporting.

39 (e) The coordinated care organization has failed to observe an order of the authority to make
40 good, within the time prescribed by law, any prohibited deficiency in its [*restricted reserves*,] capital,
41 capital stock or surplus.

42 (f) The coordinated care organization is continuing to conduct business after its contract has
43 been revoked or suspended by the authority.

44 (g) The coordinated care organization, by contract or otherwise, has done any of the following
45 unlawfully, in violation of an order of the authority or without first having obtained written ap-

1 proval of the authority:

2 (A) Totally reinsured its entire outstanding business; or

3 (B) Merged or consolidated substantially its entire property or business with another entity.

4 (h) The coordinated care organization has engaged in any transaction in which it is not au-
5 thorized to engage under the laws of the state.

6 (i) The coordinated care organization has failed to comply with any other order of the authority.

7 (j) The coordinated care organization has failed to comply with any other applicable provisions
8 of ORS 415.012 to 415.430 or rules adopted pursuant to ORS 415.011.

9 (k) The business of the coordinated care organization is being conducted fraudulently.

10 (L) The coordinated care organization agrees to supervision.

11 (3) If the authority determines that one or more conditions set forth in subsection (2) of this
12 section exist, the authority may do all of the following:

13 (a) Notify the coordinated care organization of the determination of the authority.

14 (b) Furnish to the coordinated care organization a written list of the requirements to abate the
15 condition or conditions determined to exist.

16 (c) Notify the coordinated care organization that it is under the supervision of the authority and
17 that the authority is applying this section and ORS 415.205.

18 (4) The authority may act as the supervisor to conduct the supervision and otherwise carry out
19 an order under subsection (1) of this section or may appoint another person as supervisor.

20 (5) The authority or the appointed supervisor may prohibit any person from taking any of the
21 following actions during the period of supervision without the prior approval of the authority or
22 supervisor:

23 (a) Disposing of, conveying or encumbering any of the coordinated care organization's assets or
24 its business in force.

25 (b) Withdrawing from any of the coordinated care organization's bank accounts.

26 (c) Lending any of the coordinated care organization's funds.

27 (d) Investing any of the coordinated care organization's funds.

28 (e) Transferring any of the coordinated care organization's property.

29 (f) Incurring any debt, obligation or liability on behalf of the coordinated care organization.

30 (g) Merging or consolidating the coordinated care organization with another coordinated care
31 organization or other person.

32 (h) Entering into any new reinsurance contract or treaty.

33 (i) Making any material change in management.

34 (j) Increasing salaries and benefits of officers or directors.

35 (k) Making or increasing preferential payment of bonuses, dividends or other payments deter-
36 mined by the authority to be preferential.

37 (L) Any other action affecting the business or condition of the coordinated care organization.

38 (6) The authority may apply to any circuit court for any restraining order, preliminary and
39 permanent injunctions and other orders necessary to enforce a supervision order.

40 (7) During the period of supervision, the coordinated care organization may file a written re-
41 quest for a hearing to review the supervision or any action taken or proposed to be taken. A request
42 under this subsection does not suspend the supervision. The coordinated care organization must
43 specify in the request the manner in which the action being complained of would not result in im-
44 proving the condition of the coordinated care organization. The hearing shall be held within 30 days
45 after the filing of the request. The authority shall complete the review of the supervision or other

1 action and shall take action under subsection (8) of this section if appropriate within 30 days after
 2 the record for the hearing is closed.

3 (8) The authority shall release a coordinated care organization from supervision if the authority
 4 determines upon hearing that none of the conditions giving rise to the supervision exist.

5 **SECTION 12.** Section 3 of this 2023 Act is amended to read:

6 **Sec. 3.** The Oregon Health Authority shall withhold an amount from [each] a global budget
 7 payment made to a coordinated care organization[. *The amount withheld shall be paid into a subac-*
 8 *count designated for the coordinated care organization within the Community Escrow Fund established*
 9 *under section 1 of this 2023 Act. The amount withheld shall be calculated to achieve, by January 1,*
 10 *2029, an amount equal to the restricted reserves required for the coordinated care organization under*
 11 *ORS 414.572 (1)(b)(A).] as necessary to maintain, in the subaccount designated for the coordi-*
 12 **nated care organization in the Community Escrow Fund established under section 1 of this**
 13 **2023 Act, \$250,000 plus an amount equal to 50 percent of the coordinated care organization’s**
 14 **total actual or projected liabilities for the contract year that exceed \$250,000.**

15 **SECTION 13.** The amendments to section 3 of this 2023 Act by section 12 of this 2023 Act
 16 and the amendments to ORS 414.572, 414.591, 415.011, 415.056, 415.115 and 415.204 and section
 17 2, chapter 467, Oregon Laws 2021, by sections 5 to 11 of this 2023 Act become operative on
 18 January 1, 2029.

19 **SECTION 14.** Section 4 of this 2023 Act is repealed on January 2, 2029.
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