Senate Bill 967

Sponsored by COMMITTEE ON HEALTH CARE

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.**

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

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

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

REIMBURSEMENT FOR SERVICES PROVIDED BY COORDINATED CARE ORGANIZATIONS

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

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

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.

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

(b) Meet the following minimum financial requirements:

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

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

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

(c) Operate within a fixed global budget **and other payment mechanisms described in subsection (6) of this section** and spend on primary care, as defined by the authority by rule, at least 12 percent of the coordinated care organization's total expenditures for physical and mental health care provided to members, except for expenditures on prescription drugs, vision care and dental care.

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

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

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

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

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

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

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

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

(e) Members are provided:

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

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

(C) Meaningful language access as required by federal and state law including, but not limited to, 42 U.S.C. 18116, Title VI of the Civil Rights Act of 1964, Title VI Guidance issued by the United

States Department of Justice and the National Standards for Culturally and Linguistically Appropriate Services in Health and Health Care as issued by the United States Department of Health and Human Services; and

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

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

(g) Each coordinated care organization uses health information technology to link services and care providers across the continuum of care to the greatest extent practicable and if financially viable.

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

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

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

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

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

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

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

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

(E) Include providers of specialty care.

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

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

(L) Each coordinated care organization reports on [*outcome and*] quality measures [*adopted under ORS 414.638*] **established under ORS 413.017 (4)** and participates in the health care data reporting system established in ORS 442.372 and 442.373.

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

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

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

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

[*(B) A representative of a dental care organization selected by the coordinated care organization;*]

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

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

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

(ii) A behavioral health provider;

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

[*(F)*] **(E)** At least two members of the community advisory council, one of whom is or was within the previous six months a recipient of medical assistance and is at least 16 years of age or a parent, guardian or primary caregiver of an individual who is or was within the previous six months a recipient of medical assistance.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

(a) Global budgets remain the predominant means of reimbursing coordinated care organizations for care and services provided to the coordinated care organization's members; and

(b) The other payment mechanisms are consistent with the legislative intent expressed in ORS 414.018 and the system design described in ORS 414.570 (1).

SECTION 2. ORS 414.570 is amended to read:

414.570. (1) There is established the Oregon Integrated and Coordinated Health Care Delivery System. The system shall consist of state policies and actions that make coordinated care organizations accountable for care management and provision of integrated and coordinated health care for each organization's members[*, managed within fixed global budgets,*] by providing care so that efficiency and quality improvements reduce medical cost inflation while supporting the development of regional and community accountability for the health of the residents of each region and community, and while maintaining regulatory controls necessary to ensure quality and affordable health care for all Oregonians.

(2) The Oregon Health Authority shall seek input from groups and individuals who are part of underserved communities, including ethnically diverse populations, geographically isolated groups, seniors, people with disabilities and people using mental health services, and shall also seek input from providers, coordinated care organizations and communities, in the development of strategies that promote person centered care and encourage healthy behaviors, healthy lifestyles and prevention and wellness activities and promote the development of patients' skills in self-management and illness management.

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

(a) The achievement of benchmarks;

(b) Progress toward eliminating health disparities;

(c) Results of evaluations;

(d) Rules adopted;

(e) Customer satisfaction;

(f) Use of patient centered primary care homes and behavioral health homes;

(g) The involvement of local governments in governance and service delivery; and

(h) Other developments with respect to coordinated care organizations.

QUALITY MEASURES

SECTION 3. ORS 413.017 is amended to read:

413.017. (1) The Oregon Health Policy Board shall establish the committees described in subsections (2) to (5) of this section.

(2)(a) The Public Health Benefit Purchasers Committee shall include individuals who purchase health care for the following:

(A) The Public Employees' Benefit Board.

(B) The Oregon Educators Benefit Board.

(C) Trustees of the Public Employees Retirement System.

(D) A city government.

(E) A county government.

(F) A special district.

(G) Any private nonprofit organization that receives the majority of its funding from the state and requests to participate on the committee.

(b) The Public Health Benefit Purchasers Committee shall:

(A) Identify and make specific recommendations to achieve uniformity across all public health benefit plan designs based on the best available clinical evidence, recognized best practices for health promotion and disease management, demonstrated cost-effectiveness and shared demographics among the enrollees within the pools covered by the benefit plans.

(B) Develop an action plan for ongoing collaboration to implement the benefit design alignment described in subparagraph (A) of this paragraph and shall leverage purchasing to achieve benefit uniformity if practicable.

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

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

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

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

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

[*(4)(a) The Health Plan Quality Metrics Committee shall include the following members appointed by the Oregon Health Policy Board:*]

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

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

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

[*(D) An individual representing the Department of Consumer and Business Services;*]

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

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

[*(G) One individual representing insurers, large employers or multiple employer welfare arrangements;*]

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

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

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

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

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

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

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

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

[*(A) Utilize existing state and national health outcome and quality measures, including measures adopted by the Centers for Medicare and Medicaid Services, that have been adopted or endorsed by other state or national organizations and have a relevant state or national benchmark;*]

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

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

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

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

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

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

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

[*(g) This subsection does not prevent the authority, the Department of Consumer and Business Services, commercial insurers, the Public Employees' Benefit Board or the Oregon Educators Benefit Board from establishing programs that provide financial incentives to providers for meeting specific health outcome and quality measures adopted by the committee.*]

(4)(a) The Health Equity Quality Metrics Committee shall have at least 13 members ap-

pointed by the Director of the Oregon Health Authority as follows:

(A) At least eight members who:

(i) Represent the interests of groups most affected by health inequities, including individuals enrolled in the medical assistance program; or

(ii) Are health equity researchers or professionals;

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

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

(b) The Health Equity Quality Metrics Committee shall establish quality measures and a process for developing quality measures consistent with the:

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

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

(c) The Oregon Health Authority shall evaluate on a regular and ongoing basis the quality measures established by the Health Equity Quality Metrics Committee under this subsection for members of coordinated care organizations.

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

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

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

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

[*(D)*] **(C)** A representative of a community mental health program;

[*(E)*] **(D)** An individual with expertise in data analysis;

[*(F)*] **(E)** A member of the Consumer Advisory Council, established under ORS 430.073, that represents adults with mental illness;

[*(G)*] **(F)** A representative of the System of Care Advisory Council established in ORS 418.978;

[*(H)*] **(G)** A member of the Oversight and Accountability Council, described in ORS 430.389, who represents adults with addictions or co-occurring conditions;

[*(I)*] **(H)** One member representing a system of care, as defined in ORS 418.976;

[*(J)*] **(I)** One consumer representative;

[*(K)*] **(J)** One representative of a tribal government;

[*(L)*] **(K)** One representative of an organization that advocates on behalf of individuals with intellectual or developmental disabilities;

[*(M)*] **(L)** One representative of providers of behavioral health services;

[*(N)*] **(M)** The director of the division of the authority responsible for behavioral health services, as a nonvoting member;

[*(O)*] **(N)** The Director of the Alcohol and Drug Policy Commission appointed under ORS 430.220, as a nonvoting member;

[*(P)*] **(O)** The authority's Medicaid director, as a nonvoting member;

[*(Q)*] **(P)** A representative of the Department of Human Services, as a nonvoting member; and

[*(R)*] **(Q)** Any other member that the director deems appropriate.

(b) The board may modify the membership of the committee as needed.

(c) The division of the authority responsible for behavioral health services and the director of

the division shall staff the committee.

(d) The committee[*, in collaboration with the Health Plan Quality Metrics Committee, as needed,*] shall:

(A) Establish quality metrics for behavioral health services provided by coordinated care organizations, health care providers, counties and other government entities; and

(B) Establish incentives to improve the quality of behavioral health services.

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

(A) Improve timely access to behavioral health care;

(B) Reduce hospitalizations;

(C) Reduce overdoses;

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

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

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

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

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

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

(b) Administer the Oregon Integrated and Coordinated Health Care Delivery System established in ORS 414.570, the COFA Premium Assistance Program established in ORS 413.610 and the COFA Dental Program established in section 1, chapter 87, Oregon Laws 2022;

(c) Administer the Oregon Prescription Drug Program;

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

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

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

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

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

(i) Be the state Medicaid agency for the administration of funds from Titles XIX and XXI of the Social Security Act and administer medical assistance under ORS chapter 414;

(j) In consultation with the Director of the Department of Consumer and Business Services, periodically review and recommend standards and methodologies to the Legislative Assembly for:

(A) Review of administrative expenses of health insurers;

(B) Approval of rates; and

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

(k) Structure reimbursement rates for providers that serve recipients of medical assistance to reward comprehensive management of diseases, quality outcomes and the efficient use of resources

and to promote cost-effective procedures, services and programs including, without limitation, preventive health, dental and primary care services, web-based office visits, telephone consultations and telemedicine consultations;

(L) Guide and support community three-share agreements in which an employer, state or local government and an individual all contribute a portion of a premium for a community-centered health initiative or for insurance coverage;

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

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

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

(o) Report to the Oregon Health Policy Board annually the quality measures established by the Health Equity Quality Metrics Committee and the quality metrics established by the Behavioral Health Committee under ORS 413.017.

(2) The Oregon Health Authority is authorized to:

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

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

(A) Uniform quality standards and performance measures;

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

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

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

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

(3) The enumeration of duties, functions and powers in this section is not intended to be exclusive nor to limit the duties, functions and powers imposed on or vested in the Oregon Health Authority by ORS 413.006 to 413.042, 413.610 to 413.613, 415.012 to 415.430, 415.501, 741.001 to 741.540, 741.802 and 741.900 or by other statutes.

SECTION 5. ORS 414.025 is amended to read:

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

(1)(a) "Alternative payment methodology" means a payment other than a fee-for-services payment, used by coordinated care organizations as compensation for the provision of integrated and coordinated health care and services.

(b) "Alternative payment methodology" includes, but is not limited to:

(A) Shared savings arrangements;

(B) Bundled payments; and

(C) Payments based on episodes.

(2) "Behavioral health assessment" means an evaluation by a behavioral health clinician, in person or using telemedicine, to determine a patient's need for immediate crisis stabilization.

(3) "Behavioral health clinician" means:

(a) A licensed psychiatrist;

(b) A licensed psychologist;

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

(d) A licensed clinical social worker;

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

(f) A certified clinical social work associate;

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

(h) Any other clinician whose authorized scope of practice includes mental health diagnosis and treatment.

(4) "Behavioral health crisis" means a disruption in an individual's mental or emotional stability or functioning resulting in an urgent need for immediate outpatient treatment in an emergency department or admission to a hospital to prevent a serious deterioration in the individual's mental or physical health.

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

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

(7) "Community health worker" means an individual who meets qualification criteria adopted by the authority under ORS 414.665 and who:

(a) Has expertise or experience in public health;

(b) Works in an urban or rural community, either for pay or as a volunteer in association with a local health care system;

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

(d) Assists members of the community to improve their health and increases the capacity of the community to meet the health care needs of its residents and achieve wellness;

(e) Provides health education and information that is culturally appropriate to the individuals being served;

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

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

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

(8) "Coordinated care organization" means an organization meeting criteria adopted by the Oregon Health Authority under ORS 414.572.

(9) "Dually eligible for Medicare and Medicaid" means, with respect to eligibility for enrollment in a coordinated care organization, that an individual is eligible for health services funded by Title XIX of the Social Security Act and is:

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

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

(10)(a) "Family support specialist" means an individual who meets qualification criteria adopted by the authority under ORS 414.665 and who provides supportive services to and has experience parenting a child who:

(A) Is a current or former consumer of mental health or addiction treatment; or

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

(b) A "family support specialist" may be a peer wellness specialist or a peer support specialist.

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

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

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

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

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

(c) Prescription drugs;

(d) Laboratory and X-ray services;

(e) Medical equipment and supplies;

(f) Mental health services;

(g) Chemical dependency services;

(h) Emergency dental services;

(i) Nonemergency dental services;

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

(k) Emergency hospital services;

(L) Outpatient hospital services; and

(m) Inpatient hospital services.

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

(15)(a) "Integrated health care" means care provided to individuals and their families in a patient centered primary care home or behavioral health home by licensed primary care clinicians, behavioral health clinicians and other care team members, working together to address one or more of the following:

(A) Mental illness.

(B) Substance use disorders.

(C) Health behaviors that contribute to chronic illness.

(D) Life stressors and crises.

(E) Developmental risks and conditions.

(F) Stress-related physical symptoms.

(G) Preventive care.

(H) Ineffective patterns of health care utilization.

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

(A) Qualified mental health professionals or qualified mental health associates meeting requirements adopted by the Oregon Health Authority by rule;

(B) Peer wellness specialists;

(C) Peer support specialists;

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

(E) Personal health navigators; or

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

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

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

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

(19) "Patient centered primary care home" means a health care team or clinic that is organized in accordance with the standards established by the Oregon Health Authority under ORS 414.655 and that incorporates the following core attributes:

(a) Access to care;

(b) Accountability to consumers and to the community;

(c) Comprehensive whole person care;

(d) Continuity of care;

(e) Coordination and integration of care; and

(f) Person and family centered care.

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

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

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

(21) "Peer wellness specialist" means an individual who meets qualification criteria adopted by the authority under ORS 414.665 and who is responsible for assessing mental health and substance use disorder service and support needs of a member of a coordinated care organization through community outreach, assisting members with access to available services and resources, addressing barriers to services and providing education and information about available resources for individuals with mental health or substance use disorders in order to reduce stigma and discrimination

toward consumers of mental health and substance use disorder services and to assist the member in creating and maintaining recovery, health and wellness.

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

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

(b) Reflects the clinical needs of the patient as identified through an individualized assessment; and

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

(23) "Personal health navigator" means an individual who meets qualification criteria adopted by the authority under ORS 414.665 and who provides information, assistance, tools and support to enable a patient to make the best health care decisions in the patient's particular circumstances and in light of the patient's needs, lifestyle, combination of conditions and desired outcomes.

[*(24) "Prepaid managed care health services organization" means a managed dental care, mental health or chemical dependency organization that contracts with the authority under ORS 414.654 or with a coordinated care organization on a prepaid capitated basis to provide health services to medical assistance recipients.*]

[*(25)*] **(24)** "Quality measure" means [*the health outcome and quality measures and benchmarks identified by the Health Plan Quality Metrics Committee and the metrics and scoring subcommittee*] **a standard for measuring the performance of a coordinated care organization or health care provider in the provision of care and services, including, but not limited to, the quality measures established by the Health Equity Quality Metrics Committee** in accordance with ORS 413.017 (4) [*and 414.638*] and the quality metrics developed by the Behavioral Health Committee in accordance with ORS 413.017 (5).

[*(26)*] **(25)** "Resources" has the meaning given that term in ORS 411.704. For eligibility purposes, "resources" does not include charitable contributions raised by a community to assist with medical expenses.

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

(a) Has expertise or experience in public health;

(b) Works in a tribal community or an urban Indian community, either for pay or as a volunteer in association with a local health care system;

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

(d) Assists members of the community to improve their health, including physical, behavioral and oral health, and increases the capacity of the community to meet the health care needs of its residents and achieve wellness;

(e) Provides health education and information that is culturally appropriate to the individuals being served;

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

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

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

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

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

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

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

(b) A "youth support specialist" may be a peer wellness specialist or a peer support specialist.

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

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

(1)(a) "Alternative payment methodology" means a payment other than a fee-for-services payment, used by coordinated care organizations as compensation for the provision of integrated and coordinated health care and services.

(b) "Alternative payment methodology" includes, but is not limited to:

(A) Shared savings arrangements;

(B) Bundled payments; and

(C) Payments based on episodes.

(2) "Behavioral health assessment" means an evaluation by a behavioral health clinician, in person or using telemedicine, to determine a patient's need for immediate crisis stabilization.

(3) "Behavioral health clinician" means:

(a) A licensed psychiatrist;

(b) A licensed psychologist;

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

(d) A licensed clinical social worker;

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

(f) A certified clinical social work associate;

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

(h) Any other clinician whose authorized scope of practice includes mental health diagnosis and treatment.

(4) "Behavioral health crisis" means a disruption in an individual's mental or emotional stability or functioning resulting in an urgent need for immediate outpatient treatment in an emergency department or admission to a hospital to prevent a serious deterioration in the individual's mental or physical health.

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

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

(7) "Community health worker" means an individual who meets qualification criteria adopted by the authority under ORS 414.665 and who:

(a) Has expertise or experience in public health;

(b) Works in an urban or rural community, either for pay or as a volunteer in association with a local health care system;

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

(d) Assists members of the community to improve their health and increases the capacity of the community to meet the health care needs of its residents and achieve wellness;

(e) Provides health education and information that is culturally appropriate to the individuals being served;

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

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

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

(8) "Coordinated care organization" means an organization meeting criteria adopted by the Oregon Health Authority under ORS 414.572.

(9) "Dually eligible for Medicare and Medicaid" means, with respect to eligibility for enrollment in a coordinated care organization, that an individual is eligible for health services funded by Title XIX of the Social Security Act and is:

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

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

(10)(a) "Family support specialist" means an individual who meets qualification criteria adopted by the authority under ORS 414.665 and who provides supportive services to and has experience parenting a child who:

(A) Is a current or former consumer of mental health or addiction treatment; or

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

(b) A "family support specialist" may be a peer wellness specialist or a peer support specialist.

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

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

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

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

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

(c) Prescription drugs;

(d) Laboratory and X-ray services;

(e) Medical equipment and supplies;

(f) Mental health services;

(g) Chemical dependency services;

(h) Emergency dental services;

(i) Nonemergency dental services;

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

(k) Emergency hospital services;

(L) Outpatient hospital services; and

(m) Inpatient hospital services.

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

(15)(a) "Integrated health care" means care provided to individuals and their families in a patient centered primary care home or behavioral health home by licensed primary care clinicians, behavioral health clinicians and other care team members, working together to address one or more of the following:

(A) Mental illness.

(B) Substance use disorders.

(C) Health behaviors that contribute to chronic illness.

(D) Life stressors and crises.

(E) Developmental risks and conditions.

(F) Stress-related physical symptoms.

(G) Preventive care.

(H) Ineffective patterns of health care utilization.

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

(A) Qualified mental health professionals or qualified mental health associates meeting requirements adopted by the Oregon Health Authority by rule;

(B) Peer wellness specialists;

(C) Peer support specialists;

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

(E) Personal health navigators; or

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

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

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

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

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

(a) Therapeutic class 7 ataractics-tranquilizers; and

(b) Therapeutic class 11 psychostimulants-antidepressants.

(20) "Patient centered primary care home" means a health care team or clinic that is organized in accordance with the standards established by the Oregon Health Authority under ORS 414.655 and that incorporates the following core attributes:

(a) Access to care;

(b) Accountability to consumers and to the community;

(c) Comprehensive whole person care;

(d) Continuity of care;

(e) Coordination and integration of care; and

(f) Person and family centered care.

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

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

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

(22) "Peer wellness specialist" means an individual who meets qualification criteria adopted by the authority under ORS 414.665 and who is responsible for assessing mental health and substance use disorder service and support needs of a member of a coordinated care organization through community outreach, assisting members with access to available services and resources, addressing barriers to services and providing education and information about available resources for individuals with mental health or substance use disorders in order to reduce stigma and discrimination toward consumers of mental health and substance use disorder services and to assist the member in creating and maintaining recovery, health and wellness.

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

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

(b) Reflects the clinical needs of the patient as identified through an individualized assessment; and

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

(24) "Personal health navigator" means an individual who meets qualification criteria adopted by the authority under ORS 414.665 and who provides information, assistance, tools and support to enable a patient to make the best health care decisions in the patient's particular circumstances and in light of the patient's needs, lifestyle, combination of conditions and desired outcomes.

[*(25) "Prepaid managed care health services organization" means a managed dental care, mental health or chemical dependency organization that contracts with the authority under ORS 414.654 or with a coordinated care organization on a prepaid capitated basis to provide health services to medical assistance recipients.*]

[*(26)*] **(25)** "Quality measure" means [*the health outcome and quality measures and benchmarks identified by the Health Plan Quality Metrics Committee and the metrics and scoring subcommittee*] **a standard for measuring the performance of a coordinated care organization or health care provider in the provision of care and services, including, but not limited to, the quality measures established by the Health Equity Quality Metrics Committee** in accordance with ORS 413.017 (4) [*and 414.638*] and the quality metrics developed by the Behavioral Health Committee in accordance with ORS 413.017 (5).

[*(27)*] **(26)** "Resources" has the meaning given that term in ORS 411.704. For eligibility purposes, "resources" does not include charitable contributions raised by a community to assist with medical expenses.

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

(a) Has expertise or experience in public health;

(b) Works in a tribal community or an urban Indian community, either for pay or as a volunteer in association with a local health care system;

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

(d) Assists members of the community to improve their health, including physical, behavioral and oral health, and increases the capacity of the community to meet the health care needs of its residents and achieve wellness;

(e) Provides health education and information that is culturally appropriate to the individuals being served;

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

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

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

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

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

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

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

(b) A "youth support specialist" may be a peer wellness specialist or a peer support specialist.

SECTION 7. ORS 414.591 is amended to read:

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

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

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

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

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

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

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

(E) Align, to the greatest extent practicable, with the National Association of Insurance Commissioners' reporting forms to reduce the administrative costs of coordinated care organizations

that are also regulated by the Department of Consumer and Business Services or have affiliates that are regulated by the department.

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

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

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

(c) The authority may encourage compliance with quality measures and data reporting standards by withholding a percentage of each coordinated care organization's monthly global payment during a calendar year and paying all or a portion of the amount withheld to the coordinated care organization in the following year based on the coordinated care organization's compliance with quality measures and data reporting standards. The withholdings and payments are not subject to the Oregon Department of Administrative Service's guidance on accounting and financial reporting for the withholding of state payments or distributions from nonstate entities as set forth in the Oregon Accounting Manual.

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

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

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

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

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

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

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

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

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

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

(a) Grievances and appeals; and

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

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

SECTION 8. ORS 414.686 is amended to read:

414.686. (1) A coordinated care organization shall provide an initial health assessment on any child enrolled in the coordinated care organization who is in the custody of the Department of Human Services no later than 60 days after the date that the Oregon Health Authority notifies the coordinated care organization that the child has been taken into the department's custody. [*The assessment must be performed in accordance with metrics established by the metrics and scoring subcommittee created in ORS 414.638.*]

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

SECTION 9. ORS 417.721 is amended to read:

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

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

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

(a) "Carrier" means an insurer that offers a health benefit plan, as defined in ORS 743B.005.

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

(c) "Primary care" means family medicine, general internal medicine, naturopathic medicine, obstetrics and gynecology, pediatrics or general psychiatry.

(d) "Primary care provider" includes:

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

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

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

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

(i) Increase the investment in primary care;

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

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

(B) Increase investment in primary care without increasing costs to consumers or increasing the total cost of health care;

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

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

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

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

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

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

(a) Primary care providers;

(b) Health care consumers;

(c) Experts in primary care contracting and reimbursement;

(d) Independent practice associations;

(e) Behavioral health treatment providers;

(f) Third party administrators;

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

(h) The Department of Consumer and Business Services;

(i) Carriers;

(j) A statewide organization for mental health professionals who provide primary care;

(k) A statewide organization representing federally qualified health centers;

(L) A statewide organization representing hospitals and health systems;

(m) A statewide professional association for family physicians;

(n) A statewide professional association for physicians;

(o) A statewide professional association for nurses; and

(p) The Centers for Medicare and Medicaid Services.

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

(5) A coordinated care organization shall report to the authority, no later than October 1 of each year, the proportion of the organization's total medical costs that are allocated to primary

care.

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

SECTION 11. ORS 413.011 is amended to read:

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

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

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

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

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

(A) Quality measures;

(B) Costs;

(C) Health outcomes; and

(D) Other information that is necessary for members of the public to evaluate the value of health services delivered by each coordinated care organization and by each health benefit plan.

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

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

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

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

(i) Work with the Oregon congressional delegation to advance the adoption of changes in federal law or policy to promote Oregon's comprehensive health reform plan.

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

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

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

(B) A payroll tax as a means to encourage employers to continue providing health insurance to their employees.

(L) Meet cost-containment goals by structuring reimbursement rates to reward comprehensive management of diseases, quality outcomes and the efficient use of resources by promoting cost-

effective procedures, services and programs including, without limitation, preventive health, dental and primary care services, web-based office visits, telephone consultations and telemedicine consultations.

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

(n) Work with the Public Health Benefit Purchasers Committee, administrators of the medical assistance program and the Department of Corrections to identify uniform contracting standards for health benefit plans that achieve maximum quality and cost outcomes and align the contracting standards for all state programs to the greatest extent practicable.

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

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

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

(b) Submit directly to the Legislative Counsel, no later than October 1 of each even-numbered year, requests for measures necessary to provide statutory authorization to carry out any of the board's duties or to implement any of the board's recommendations. The measures may be filed prior to the beginning of the legislative session in accordance with the rules of the House of Representatives and the Senate.

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

(4) The enumeration of duties, functions and powers in this section is not intended to be exclusive nor to limit the duties, functions and powers imposed on the board by ORS 413.006 to 413.042 and 741.340 and by other statutes.

(5) The board shall consult with the Department of Consumer and Business Services in completing the tasks set forth in subsection (1)(j) and (k)(A) of this section.

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

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

(a) Employee choice among high quality plans;

(b) A competitive marketplace;

(c) Plan performance and information;

(d) Employer flexibility in plan design and contracting;

(e) Quality customer service;

(f) Creativity and innovation;

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

(h) The improvement of employee health; and

(i) [*Health outcome and*] Quality measures, [*described in*] **established under** ORS 413.017 (4), that are reported by the plan.

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

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

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

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

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

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

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

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

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

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

(11) No later than February 1 of each year, the board shall report to the Legislative Assembly on any plan implemented under subsection (10) of this section and on the board's progress toward achieving the target of spending at least 12 percent of total medical expenditures in self-insured

health benefit plans on payments for primary care.

SECTION 13. ORS 243.866, as amended by section 17, chapter 489, Oregon Laws 2017, and section 4, chapter 484, Oregon Laws 2019, is amended to read:

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

(a) Employee choice among high-quality plans;

(b) Encouragement of a competitive marketplace;

(c) Plan performance and information;

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

(e) Quality customer service;

(f) Creativity and innovation;

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

(h) Improvement of employee health; and

(i) [*Health outcome and*] Quality measures, [*described in*] **established under** ORS 413.017 (4), that are reported by the plan.

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

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

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

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

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

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

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

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

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

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

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

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

DISCONTINUANCE OF STAND-ALONE PREPAID MANAGED CARE HEALTH SERVICES ORGANIZATIONS

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

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

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

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

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

(c) "State Medicaid agency" means a state agency responsible for administering Medicaid under 42 U.S.C. 1396a (section 1902 of the Social Security Act).

(2) A health insurer is prohibited from considering the availability or eligibility for medical assistance in this or any other state [*under Medicaid*] when considering eligibility for coverage or making payments under its group or individual plan for eligible enrollees, subscribers, policyholders or certificate holders.

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

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

(a) The claim is submitted by the agency[*, the prepaid managed care health services organization*] or the coordinated care organization within the three-year period beginning on the

date on which the health care item or service was furnished; and

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

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

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

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

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

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

(a) The child was born out of wedlock;

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

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

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

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

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

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

(8) When a parent is required by a court or administrative order to provide health coverage for a child, and the parent is eligible for family health coverage, the insurer must:

(a) Permit the parent to enroll, under the family coverage, a child who is otherwise eligible for the coverage without regard to any enrollment season restrictions;

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

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

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

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

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

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

SECTION 15. ORS 192.395 is amended to read:

192.395. A record of an agency of the executive department as defined in ORS 174.112 that

contains the following information is a public record subject to inspection under ORS 192.314 and is not exempt from disclosure under ORS 192.345 or 192.355 except to the extent that the record discloses information about an individual's health or is proprietary to a person:

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

(a) Inpatient hospital services;

(b) Outpatient hospital services;

(c) Laboratory and X-ray services;

(d) Physician and other licensed practitioner services;

(e) Prescription drugs;

(f) Dental services;

(g) Vision services;

(h) Mental health services;

(i) Chemical dependency services;

(j) Durable medical equipment and supplies; and

(k) Other health services provided under a coordinated care organization contract under ORS 414.591 [*or a contract with a prepaid managed care health services organization, as defined in ORS 414.025*];

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

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

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

SECTION 16. ORS 192.579 is amended to read:

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

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

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

413.550. As used in ORS 413.550 to 413.559:

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

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

(3) "Health care" means medical, surgical, oral or hospital care or any other remedial care recognized by state law, including physical and behavioral health care.

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

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

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

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

(D) Sight translate documents from a person with limited English proficiency; and

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

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

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

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

(a) An individual licensed or certified by the:

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

(B) State Board of Chiropractic Examiners;

(C) State Board of Licensed Social Workers;

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

(E) Oregon Board of Dentistry;

(F) State Board of Massage Therapists;

(G) Oregon Board of Naturopathic Medicine;

(H) Oregon State Board of Nursing;

(I) Oregon Board of Optometry;

(J) State Board of Pharmacy;

(K) Oregon Medical Board;

(L) Occupational Therapy Licensing Board;

(M) Oregon Board of Physical Therapy;

(N) Oregon Board of Psychology;

(O) Board of Medical Imaging;

(P) State Board of Direct Entry Midwifery;

(Q) Respiratory Therapist and Polysomnographic Technologist Licensing Board;

(R) Board of Registered Polysomnographic Technologists;

(S) Board of Licensed Dietitians; and

(T) State Mortuary and Cemetery Board;

(b) An emergency medical services provider licensed by the Oregon Health Authority under ORS 682.216;

(c) A clinical laboratory licensed under ORS 438.110;

(d) A health care facility as defined in ORS 442.015;

(e) A home health agency licensed under ORS 443.015;

(f) A hospice program licensed under ORS 443.860; or

(g) Any other person that provides health care or that bills for or is compensated for health care provided, in the normal course of business.

(7) "Interpretation service company" means an entity, or a person acting on behalf of an entity,

that is in the business of arranging for health care interpreters to work with health care providers in this state.

(8) "Person with limited English proficiency" means a person who, by reason of place of birth or culture, communicates in a language other than English and does not communicate in English with adequate ability to communicate effectively with a health care provider.

[*(9) "Prepaid managed care health services organization" has the meaning given that term in ORS 414.025.*]

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

[*(11)*] **(10)** "Sight translate" means to translate a written document into spoken or signed language.

SECTION 18. ORS 414.430 is amended to read:

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

(a) Emergency dental services;

(b) Urgent dental services;

(c) Routine dental services; and

(d) An initial dental screening or examination.

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

SECTION 19. ORS 414.619 is amended to read:

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

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

SECTION 20. ORS 414.631 is amended to read:

414.631. (1) Except as provided in subsections [*(2), (3), (4) and (5)*] **(2) and (3)** of this section and ORS 414.632 (2), a person who is eligible for or receiving health services must be enrolled in a coordinated care organization to receive the health services for which the person is eligible. For purposes of this subsection, Medicaid-funded long term care services do not constitute health services.

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

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

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

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

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

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

(B) A woman in her third trimester of pregnancy at the time of enrollment;

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

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

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

(F) A person with major medical coverage.

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

[*(4) In any area that is not served by a coordinated care organization but is served by a prepaid managed care health services organization, a person must enroll with the prepaid managed care health services organization to receive any of the health services offered by the prepaid managed care health services organization.*]

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

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

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

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

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

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

(c) A person who is considered by the United States Secretary of the Interior to be an Indian for any purpose; or

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

SECTION 21. ORS 414.764 is amended to read:

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

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

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

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

(2) A coordinated care organization may reimburse a pharmacist or pharmacy for any health service:

(a) Provided to a medical assistance recipient who is enrolled in the coordinated care organization [*or a prepaid managed care health services organization*] that enters into a clinical pharmacy agreement with the pharmacist or pharmacy; and

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

SECTION 22. ORS 414.880 is amended to read:

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

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

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

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

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

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

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

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

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

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

SECTION 23. ORS 414.902 is amended to read:

414.902. (1) If a [*managed*] **coordinated** care organization fails to timely pay an assessment under ORS 414.880, the Oregon Health Authority shall impose a penalty on the [*managed*] **coordinated** care organization of up to $500 per day of delinquency. The total amount of penalties imposed under this section for a calendar quarter may not exceed five percent of the assessment due for that calendar quarter.

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

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

SECTION 24. ORS 415.500 is amended to read:

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

(1) "Corporate affiliation" has the meaning prescribed by the Oregon Health Authority by rule, including:

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

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

(2) "Essential services" means:

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

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

(3) "Health benefit plan" has the meaning given that term in ORS 743B.005.

(4)(a) "Health care entity" includes:

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

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

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

(D) A Medicare Advantage plan;

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

(F) Any other entity that has as a primary function the provision of health care items or services or that is a parent organization of, or is an entity closely related to, an entity that has as a

primary function the provision of health care items or services.

(b) "Health care entity" does not include:

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

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

(5) "Health equity" has the meaning prescribed by the Oregon Health Policy Board and adopted by the authority by rule.

(6)(a) "Material change transaction" means:

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

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

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

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

(b) "Material change transaction" does not include:

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

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

(C) An affiliation that:

(i) Does not impact the corporate leadership, governance or control of an entity; and

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

(D) Contracts under which one health care entity, for and on behalf of a second health care entity, provides patient care and services or provides administrative services relating to, supporting or facilitating the provision of patient care and services, if the second health care entity:

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

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

(E) Transactions in which a participant that is a health center as defined in 42 U.S.C. 254b, while meeting all of the participant's obligations, acquires, affiliates with, partners with or enters into any agreement with another entity unless the transaction would result in the participant no longer qualifying as a health center under 42 U.S.C. 254b.

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

(A) A carrier and an independent practice association;

(B) A carrier, coordinated care organization, independent practice association or network of providers and one or more providers, as defined in ORS 743B.001;

(C) An independent practice association and an individual health professional or an organization of health care providers;

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

(E) A medical, dental, vision or mental health clinic and an individual health professional to provide medical, dental, vision or mental health services.

(b) "Medical services contract" does not include a contract of employment or a contract creating a legal entity and ownership of the legal entity that is authorized under ORS chapter 58, 60 or

70 or under any other law authorizing the creation of a professional organization similar to those authorized by ORS chapter 58, 60 or 70, as may be prescribed by the authority by rule.

(8) "Net patient revenue" means the total amount of revenue, after allowance for contractual amounts, charity care and bad debt, received for patient care and services, including:

(a) Value-based payments;

(b) Incentive payments;

(c) Capitation payments or payments under any similar contractual arrangement for the prepayment or reimbursement of patient care and services; and

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

(9) "Revenue" means:

(a) Net patient revenue; or

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

(10) "Transaction" means:

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

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

(c) New contracts, new clinical affiliations and new contracting affiliations that will eliminate or significantly reduce, as defined by the authority by rule, essential services;

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

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

SECTION 25. ORS 416.510 is amended to read:

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

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

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

(3) "Applicant" means an applicant for assistance.

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

(5) "Authority" means the Oregon Health Authority.

(6) "Claim" means a claim of a recipient of assistance for damages for personal injuries against any person or public body, agency or commission other than the State Accident Insurance Fund Corporation or Workers' Compensation Board.

(7) "Compromise" means a compromise between a recipient and any person or public body, agency or commission against whom the recipient has a claim.

(8) "Coordinated care organization" means an organization that meets the criteria adopted by the authority under ORS 414.572.

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

[*(10) "Prepaid managed care health services organization" has the meaning given that term in ORS 414.025.*]

[*(11)*] **(10)** "Recipient" means a recipient of assistance.

[*(12)*] **(11)** "Settlement" means a settlement between a recipient and any person or public body, agency or commission against whom the recipient has a claim.

SECTION 26. ORS 416.540 is amended to read:

416.540. (1) Except as provided in subsection (2) of this section and in ORS 416.590, the Department of Human Services and the Oregon Health Authority shall have a lien upon the amount of any judgment in favor of a recipient or amount payable to the recipient under a settlement or compromise for all assistance received by such recipient from the date of the injury of the recipient to the date of satisfaction of such judgment or payment under such settlement or compromise.

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

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

(a) During a period for which the authority paid a capitation or enrollment fee or a payment using a global payment methodology; and

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

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

(5) For the purposes of ORS 416.510 to 416.610, the authority may designate the [*prepaid managed care health services organization or the*] coordinated care organization to which a lien is assigned as its designee.

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

SECTION 27. ORS 646.639 is amended to read:

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

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

(b) "Consumer" means a natural person who purchases or acquires property, services or credit for personal, family or household purposes.

(c) "Consumer transaction" means a transaction between a consumer and a person that sells, leases or provides property, services or credit to consumers.

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

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

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

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

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

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

(i) "Debtor" means a consumer who owes or allegedly owes a debt, including a consumer who owes an amount that differs from the amount that a debt collector attempts to collect or that a debt buyer purchased or attempts to collect.

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

(k) "Original creditor" means the last entity that extended credit to a consumer to purchase goods or services, to lease goods or as a loan of moneys.

(L) "Person" means an individual, corporation, trust, partnership, incorporated or unincorporated association or any other legal entity.

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

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

(b) Threatens arrest or criminal prosecution.

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

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

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

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

(g) Communicates without a debtor's permission or threatens to communicate with the debtor at the debtor's place of employment if the place of employment is other than the debtor's residence, except that the debt collector may:

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

(B) Telephone a debtor's place of employment without informing any other person of the nature of the call or identifying the caller as a debt collector but only if the debt collector in good faith has made an unsuccessful attempt to telephone the debtor at the debtor's residence during the day or during the evening between the hours of 6 p.m. and 9 p.m. The debt collector may not contact the debtor at the debtor's place of employment more frequently than once each business week and may not telephone the debtor at the debtor's place of employment if the debtor notifies the debt collector not to telephone at the debtor's place of employment or if the debt collector knows or has reason to know that the debtor's employer prohibits the debtor from receiving such communication. For the purposes of this subparagraph, any language in any agreement, contract or instrument that creates or is evidence of the debt and that purports to authorize telephone calls at the debtor's place of employment does not give permission to the debt collector to call the debtor at the debtor's place of employment.

(h) Communicates with a debtor in writing without clearly identifying the name of the debt collector, the name of the person, if any, for whom the debt collector is attempting to collect the debt and the debt collector's business address, on all initial communications. In subsequent commu-

nications involving multiple accounts, the debt collector may eliminate the name of the person, if any, for whom the debt collector is attempting to collect the debt and substitute the term "various" in place of the person's name.

(i) Communicates with a debtor orally without disclosing to the debtor, within 30 seconds after beginning the communication, the name of the individual who is initiating the communication and the true purpose of the communication.

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

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

(L) Uses any form of communication that simulates legal or judicial process or that appears to be authorized, issued or approved by a governmental agency, governmental official or an attorney at law if the corresponding governmental agency, governmental official or attorney at law has not in fact authorized or approved the communication.

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

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

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

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

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

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

(B) For purposes of this paragraph, [*a prepaid managed care health services organization,*] a coordinated care organization or a public body, as defined in ORS 174.109, or an agent or assignee of the organization or public body, is not a debt collector if the organization or public body seeks to collect a debt that arises under ORS 416.540.

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

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

(t) Collects or attempts to collect a debt if the debt collector is a debt buyer, or is acting on a

debt buyer's behalf, and collects or attempts to collect purchased debt before providing to a debtor, within 30 days after the date of the debtor's request, all of the documents listed in subsection (4)(b) of this section.

(u) Collects or attempts to collect a debt without complying with the requirements of ORS 646A.677.

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

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

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

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

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

(B) The name and address of the debtor;

(C) The name, address and telephone number of the person that owns the debt and a statement as to whether the person is a debt buyer;

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

(E) A detailed and itemized statement of:

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

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

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

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

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

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

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

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

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

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

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

(ii) A copy of the most recent monthly statement that shows a purchase transaction or balance

transfer or the debtor's last payment, if the debtor made a payment, if the debt is a credit card debt or other debt for which a contract or other writing that is evidence of the debt does not exist;

(c) Fails to provide to a debtor, after the debt buyer or debt collector receives payment in cash or the debtor requests the receipt, a receipt that:

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

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

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

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

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

SECTION 28. ORS 679.540 is amended to read:

679.540. (1) As used in this section:

(a) "Dental provider" means a licensed dentist, dental hygienist or other dental practitioner or a dental care team or clinic that provides the following core services:

(A) Comprehensive dental care;

(B) Basic preventive dental services;

(C) Referral to dental specialists; and

(D) Family centered dental care.

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

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

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

(a) The performance of dental risk assessments; and

(b) The provision of oral disease prevention services.

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

(a) Refer patients to dental providers; and

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

SECTION 29. ORS 741.300 is amended to read:

741.300. As used in ORS 741.001 to 741.540:

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

(2) "Essential health benefits" has the meaning given that term in ORS 731.097.

(3) "Health benefit plan" has the meaning given that term in ORS 743B.005.

(4) "Health care service contractor" has the meaning given that term in ORS 750.005.

(5) "Health insurance" has the meaning given that term in ORS 731.162, excluding disability income insurance.

(6) "Health insurance exchange" or "exchange" means the division of the Oregon Health Authority that operates an American Health Benefit Exchange as described in 42 U.S.C. 18031, 18032, 18033 and 18041.

(7) "Health plan" means a health benefit plan or dental only benefit plan offered by an insurer.

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

(9) "Insurance producer" has the meaning given that term in ORS 731.104.

[*(10) "Prepaid managed care health services organization" has the meaning given that term in ORS 414.025.*]

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

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

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

SECTION 30. ORS 743.029 is amended to read:

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

(a) Eligibility inquiry and response;

(b) Claim submission;

(c) Payment remittance advice;

(d) Claims payment or electronic funds transfer;

(e) Claims status inquiry and response;

(f) Claims attachments;

(g) Prior authorization;

(h) Provider credentialing; or

(i) Health care financial and administrative transactions identified by the stakeholder work group described in ORS 743.031.

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

(a) Health insurers.

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

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

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

[*(e)*] **(d)** Any person or public body that either individually or jointly establishes a self-insurance plan, program or contract, including but not limited to persons and public bodies that are otherwise exempt from the Insurance Code under ORS 731.036.

[*(f)*] **(e)** Health care clearinghouses or other entities that process or facilitate the processing of health care financial and administrative transactions from a nonstandard format to a standard format.

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

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

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

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

[*(a) "Dental care organization" means a prepaid managed care health services organization, as defined in ORS 414.025, that provides dental care to members of a coordinated care organization.*]

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

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

(c) "Veteran" means an individual who is a veteran, as defined in ORS 408.225, except the individual may be discharged or released under honorable or other than honorable conditions.

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

(3) The authority shall contract with [*dental*] **coordinated** care organizations throughout this state and with individual oral health care providers in areas of this state that are not served by [*dental*] **coordinated** care organizations to provide oral health care to veterans enrolled in the Veterans Dental Program.

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

(5) An individual is eligible for the Veterans Dental Program if the individual:

(a) Is a resident of Oregon;

(b) Is ineligible for medical assistance;

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

(d) Is a veteran.

(6) The authority shall:

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

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

(c) Require and accept as verification of eligibility:

(A) Documentation demonstrating that an applicant's income is at or below 400 percent of the federal poverty guidelines.

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

SECTION 32. Section 1, chapter 87, Oregon Laws 2022, is amended to read:

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

(a) "COFA citizen" has the meaning given that term in ORS 413.611.

[*(b) "Dental care organization" means a prepaid managed care health services organization, as defined in ORS 414.025, that provides dental care to members of a coordinated care organization.*]

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

(c) "Income" means the modified adjusted gross income that is attributed to an individual in determining the individual's eligibility for the medical assistance program.

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

(3) The authority shall contract with [*dental*] **coordinated** care organizations throughout this state, and with individual oral health care providers in areas of this state that are not served by [*dental*] **coordinated** care organizations, to provide oral health care to COFA citizens enrolled in the COFA Dental Program.

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

(5) An individual is eligible for the COFA Dental Program if the individual:

(a) Is a resident of Oregon;

(b) Is a COFA citizen;

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

(d) Does not qualify for Medicaid under Title XIX of the Social Security Act or the Children's Health Insurance Program under Title XXI of the Social Security Act.

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

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

(8) The authority shall conduct outreach as described in ORS 413.612 (4)(e) to facilitate applications for and enrollment in the COFA Dental Program.

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

SECTION 33. ORS 413.181 is amended to read:

413.181. (1) The Department of Consumer and Business Services and the Oregon Health Authority may enter into agreements governing the disclosure of information reported to the department by insurers with certificates of authority to transact insurance in this state and the disclosure of information reported to the Oregon Health Authority by coordinated care organizations.

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

SECTION 34. ORS 414.607 is amended to read:

414.607. (1) The Oregon Health Authority shall ensure the appropriate use of member information by coordinated care organizations, including the use of electronic health information and ad-

ministrative data that is available when and where the data is needed to improve health and health care through a secure, confidential health information exchange.

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

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

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

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

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

SECTION 35. ORS 414.882 is amended to read:

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

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

SECTION 36. ORS 414.884 is amended to read:

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

REPEALS

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

(2) ORS 414.654 is repealed.

APPLICABILITY

SECTION 38. **Notwithstanding the amendments to ORS 413.017 and 414.025 by sections 3, 5 and 6 of this 2023 Act and the repeal of ORS 414.638 by section 37 of this 2023 Act, the metrics and scoring subcommittee created in ORS 414.638 shall select the quality measures that apply to coordinated care organization contracts in the calendar years up to and including the calendar year in which the Health Equity Quality Metrics Committee establishes quality measures.**

CAPTIONS

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

EMERGENCY CLAUSE

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