SB 966-3
(LC 468)
4/3/23 (LHF/ps)

Requested by SENATE COMMITTEE ON HEALTH CARE

PROPOSED AMENDMENTS TO
SENATE BILL 966

On page 1 of the printed bill, line 2, delete "413.032, 414.025" and insert "243.135, 243.866, 413.017, 413.032, 414.025, 414.570, 414.572, 414.638, 414.686, 417.721".

In line 3, after the second "and" insert "section 2, chapter 575, Oregon Laws 2015,".

In line 5, after "413.613" insert "; and declaring an emergency".

Delete lines 10 through 26 and delete page 2.

On page 3, delete lines 1 through 37 and insert:

"SECTION 1. ORS 442.373 is amended to read:

"442.373. (1) The Oregon Health Authority shall establish and maintain a program that requires reporting entities to report health care data for the following purposes:

"(a) Determining the maximum capacity and distribution of existing resources allocated to health care.

"(b) Identifying the demands for health care.

"(c) Allowing health care policymakers to make informed choices.

"(d) Evaluating the effectiveness of intervention programs in improving health outcomes.

"(e) Comparing the costs and effectiveness of various treatment settings and approaches.

"(f) Providing information to consumers and purchasers of health care.

"(g) Improving the quality and affordability of health care and health care coverage.

"(h) Assisting the authority in furthering the health policies expressed by the Legislative Assembly in ORS 442.310.

"(i) Evaluating health disparities, including but not limited to disparities related to race and ethnicity.

"(2) The authority shall prescribe by rule standards [*that are consistent with standards adopted by the Accredited Standards Committee X12 of the American National Standards Institute, the Centers for Medicare and Medicaid Services and the National Council for Prescription Drug Programs*] that:

"(a) Establish the time, place, form and manner of reporting data under this section, including but not limited to:

"(A) Requiring the use of unique patient and provider identifiers;

"(B) Specifying a uniform coding system that reflects all health care utilization and costs for health care services provided to Oregon residents in other states; and

"(C) Establishing enrollment thresholds below which reporting will not be required.

"(b) Establish the types of data to be reported under this section, including but not limited to:

"(A) Health care claims and enrollment data used by reporting entities and paid health care claims data;

"(B) Reports, schedules, statistics or other data relating to health care costs, prices, quality, utilization or resources determined by the authority to be necessary to carry out the purposes of this section; and

"(C) Data related to race, ethnicity**, disability, sexual orientation, gender identity** and primary language collected in a manner consistent with [*established national standards*] **ORS 413.161**.

"(3) Any third party administrator that is not required to obtain a license

under ORS 744.702 and that is legally responsible for payment of a claim for a health care item or service provided to an Oregon resident may report to the authority the health care data described in subsection (2) of this section.

"(4) The authority shall adopt rules establishing requirements for reporting entities to train providers on protocols for collecting race, ethnicity**, disability, sexual orientation, gender identity** and primary language data in a culturally competent manner.

"(5)(a) The authority shall use data collected under this section to provide information to consumers of health care to empower the consumers to make economically sound and medically appropriate decisions. The information must include, but not be limited to, the prices and quality of health care services.

"(b) The authority shall, using only data collected under this section from reporting entities described in ORS 442.372 (1) to (3), post to its website health care price information including the median prices paid by the reporting entities to hospitals and hospital outpatient clinics for, at a minimum, the 50 most common inpatient procedures and the 100 most common outpatient procedures.

"(c) The health care price information posted to the website must be:

"(A) Displayed in a consumer friendly format;

"(B) Easily accessible by consumers; and

"(C) Updated at least annually to reflect the most recent data available.

"(d) The authority shall apply for and receive donations, gifts and grants from any public or private source to pay the cost of posting health care price information to its website in accordance with this subsection. Moneys received shall be deposited to the Oregon Health Authority Fund.

"(e) The obligation of the authority to post health care price information to its website as required by this subsection is limited to the extent of any moneys specifically appropriated for that purpose or available from donations, gifts and grants from private or public sources.

"(6) The authority may contract with a third party to collect and process the health care data reported under this section. The contract must prohibit the collection of Social Security numbers and must prohibit the disclosure or use of the data for any purpose other than those specifically authorized by the contract. The contract must require the third party to transmit all data collected and processed under the contract to the authority.

"(7) The authority shall facilitate a collaboration between the Department of Human Services, the authority, the Department of Consumer and Business Services and interested stakeholders to develop a comprehensive health care information system using the data reported under this section and collected by the authority under ORS 442.370 and 442.400 to 442.463. The authority, in consultation with interested stakeholders, shall:

"(a) Formulate the data sets that will be included in the system;

"(b) Establish the criteria and procedures for the development of limited use data sets;

"(c) Establish the criteria and procedures to ensure that limited use data sets are accessible and compliant with federal and state privacy laws; and

"(d) Establish a time frame for the creation of the comprehensive health care information system.

"(8) Information disclosed through the comprehensive health care information system described in subsection (7) of this section:

"(a) Shall be available, when disclosed in a form and manner that ensures the privacy and security of personal health information as required by state and federal laws, as a resource to **researchers,** insurers, employers, providers, purchasers of health care and state agencies to allow for continuous review of health care utilization, expenditures and performance in this state;

"(b) Shall be available to Oregon programs for quality in health care for use in improving health care in Oregon, subject to rules prescribed by the authority conforming to state and federal privacy laws or limiting access to limited use data sets;

"(c) Shall be presented to allow for comparisons of geographic, demographic and economic factors and institutional size; and

"(d) May not disclose trade secrets of reporting entities **or self-funded, employer-sponsored health insurance plans regulated under the Employee Retirement Income Security Act of 1974, as codified and amended at 29 U.S.C. 1001, et seq., that report health care data voluntarily**.

"(9) The collection, storage and release of health care data and other information under this section is subject to the requirements of the federal Health Insurance Portability and Accountability Act.

"(10)(a) Notwithstanding subsection (9) of this section, in addition to the comprehensive health care information system described in subsection (7) of this section, the Department of Consumer and Business Services shall be allowed to access, use and disclose data collected under this section by certifying in writing that the data will be used only to carry out the department's duties.

"(b) Personally identifiable information disclosed to the department under paragraph (a) of this subsection, including a consumer's name, address, telephone number or electronic mail address, is confidential and not subject to further disclosure under ORS 192.311 to 192.478.

"**(11) The authority may impose a charge for information disclosed to researchers, insurers, employers, providers and purchasers of health care under subsection (8) of this section in an amount necessary to cover the authority's actual costs for collecting and releasing the information that is requested.**".

On page 8, line 19, delete "Health Plan Quality Metrics Committee" and insert "Metrics and Scoring Committee".

On page 12, line 20, after "means" delete the rest of the line and delete line 21.

In line 22, delete "accordance with ORS 413.017 (4) and" and insert "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 health outcome and quality measures established by the Metrics and Scoring Committee under ORS".

In line 23, delete "(5)" and insert "(4)".

On page 16, line 35, after "means" delete the rest of the line and delete line 36.

In line 37, delete "accordance with ORS 413.017 (4) and" and insert "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 health outcome and quality measures established by the Metrics and Scoring Committee under ORS".

In line 38, delete "(5)" and insert "(4)".

On page 20, after line 44 insert:

"**HEALTH PLAN METRICS**

"SECTION 13. ORS 414.638 is amended to read:

"414.638. **(1) As used in this section:**

"(a) 'Downstream health outcome and quality measures' means quality measures that predominantly address preventive, acute, emergent and other care generally received in clinical settings, including member experience of care.

"(b) 'Upstream health outcome and quality measures' means quality measures that focus on the root causes of health inequities, such as socioeconomic factors and racism.

"[*(1)*] **(2)** There is created in the [*Health Plan Quality Metrics Committee*] **Oregon Health Policy Board** a nine-member [*metrics and scoring subcommittee*] **Metrics and Scoring Committee** appointed by the Director of the Oregon Health Authority. The members of the [*subcommittee*]

committee serve two-year terms and must include:

"(a) Three members at large;

"(b) Three individuals with expertise in health outcomes measures; and

"(c) Three representatives of coordinated care organizations.

"**(3) The committee shall select downstream health outcome and quality measures applicable to services provided by coordinated care organizations, selected from the applicable quality measures developed for the Medicaid program in accordance with 42 U.S.C. 1320b-9a and 42 U.S.C. 1320b-9b.**

"(4) The committee shall select a minimum of four upstream health outcome and quality measures applicable to services provided by coordinated care organizations.

"(5) All health outcome and quality measures must be 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.

"(6) The committee shall use a public process when identifying the health outcome and quality measures under this subsection and provide an opportunity for public comment.

"[*(2) The subcommittee shall select, from the health outcome and quality measures identified by the Health Plan Quality Metrics Committee, the health outcome and quality measures applicable to services provided by coordinated care organizations.*]

"**(7)** The Oregon Health Authority **and the board** shall incorporate these measures into coordinated care organization contracts to hold the organizations accountable for performance and customer satisfaction requirements. The authority shall notify each coordinated care organization of any changes

in the measures at least three months before the beginning of the contract period during which the new measures will be in place.

"[*(3) The subcommittee shall evaluate the health outcome and quality measures annually, reporting recommendations based on its findings to the Health Plan Quality Metrics Committee, and adjust the measures to reflect:*]

"[*(a) The amount of the global budget for a coordinated care organization;*]

"[*(b) Changes in membership of the organization;*]

"[*(c) The organization's costs for implementing outcome and quality measures; and*]

"[*(d) The community health assessment and the costs of the community health assessment conducted by the organization under ORS 414.575.*]

"[*(4)*] **(8)** The authority shall evaluate on a regular and ongoing basis the outcome and quality measures selected by the [*subcommittee*] **committee** under this section for members in each coordinated care organization and for members statewide.

"**(9) Members of the committee who are not members of the Oregon Health Policy Board may receive compensation and the reimbursement of actual and necessary travel and other expenses incurred by them in the performance of their official duties in accordance with criteria adopted by the authority by rule and shall be reimbursed from funds available to the board in the manner and amount provided in ORS 292.495.**

"SECTION 14. ORS 414.638 is added to and made a part of ORS chapter 413.

"SECTION 15. (1) Notwithstanding ORS 414.638 (3), the downstream health outcome and quality measures for reporting year 2024 shall be selected by the Metrics and Scoring Committee from the Health Plan Quality Metrics Committee's Aligned Measure Menu Set adopted by the Health Plan Quality Metrics Committee as of the effective date of

this 2023 Act.

"(2) Notwithstanding ORS 414.638 (4), until September 30, 2027, the Metrics and Scoring Committee may prioritize the following upstream health outcome and quality measures, at a minimum:

"(a) Health assessments for children in the custody of the Department of Human Services.

"(b) Addressing the social and emotional health of young children to ensure the children are prepared for kindergarten.

"(c) Meaningful language access to culturally responsive health care services.

"(d) Screening for social needs and referrals to address the social determinants of health.

"SECTION 16. 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.*]

"[*(5)(a)*] **(4)(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*] **Metrics and Scoring 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)*] **(5)** Members of the committees described in subsections (2) to [*(5)*] **(4)** 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 ex-

penses incurred by them by their attendance at committee meetings, in the manner and amount provided in ORS 292.495.

"SECTION 17. 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*] **health outcome and quality measures** established by the [*metrics and scoring subcommittee*] **Metrics and Scoring Committee** 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 18. Individuals who are members of the metrics and scoring subcommittee under ORS 414.638 (2021 Edition) on the day before the effective date of this 2023 Act may continue to serve on the Metrics and Scoring Committee under the amendments to ORS 414.638 by section 13 of this 2023 Act for the duration of their terms and may be reappointed.

"SECTION 19. 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*] **Metrics and Scoring** Committee [*established*] **created** in ORS [*413.017*] **414.638**;

"(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 20. 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 ORS [*413.017 (4)*] **414.638**, 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 21. 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 ORS [*413.017 (4)*] **414.638**, 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.

"SECTION 22. ORS 417.721 is amended to read:

"417.721. The Oregon Health Authority, the [*Health Plan Quality Metrics Committee*] **Metrics and Scoring Committee created under ORS 414.638** 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.

"COORDINATED CARE ORGANIZATION QUALITY INCENTIVE STUDY

"SECTION 23. (1) The Oregon Health Authority shall study the coordinated care organization quality incentive program administered by the authority and the structure of the Metrics and Scoring Committee, created in ORS 414.638, to develop recommendations for programmatic changes and changes to the committee structure so that the design of the coordinated care organization quality incentive program is primarily focused on addressing health inequities, including the structural drivers of health inequities.

"(2) In conducting the study, the authority shall work with individuals whose health is most affected by the medical assistance program and individuals from communities most harmed by health inequities. The authority shall also engage with metrics experts, health care providers, coordinated care organizations and other health system representatives.

"(3) Not later than September 15, 2024, the authority shall report to the interim committees of the Legislative Assembly related to health, in the manner provided in ORS 192.245, the findings and recommendations from the study and may include recommendations for legislation.

"SECTION 24. Section 23 of this 2023 Act is repealed on January 2,

2025.

"REIMBURSEMENT FOR SERVICES PROVIDED BY COORDINATED CARE ORGANIZATIONS

"SECTION 25. 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, **predominantly** 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.

"SECTION 26. 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:

"(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 coor-

dinated 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 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) The major components of the health care delivery system;

"(D) 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) 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) 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.

"**(6) 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;

"(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); and

"(c) The payment mechanisms support the health care services approved for the demonstration project under 42 U.S.C. 1315 by the Centers for Medicare and Medicaid Services or other written federal guidance.".

On page 21, line 3, delete "13" and insert "27".

After line 5, insert:

"**EMERGENCY CLAUSE**

"SECTION 28. 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.".
