House Bill 2224

Introduced and printed pursuant to House Rule 12.00. Presession filed (at the request of House Interim Committee on Behavioral Health and Health Care for Representative Rob Nosse)

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.** The statement includes a measure digest written in compliance with applicable readability standards.

Digest: The Act makes changes to laws governing CCOs to include local health officials. (Flesch Readability Score: 63.4).

Modifies the membership of the metrics and scoring subcommittee of the Health Plan Quality Metrics Committee to include a member with expertise in public health or population health data. Modifies the membership of the Medicaid Advisory Committee to include professionals with experience in providing public health, behavioral health and health-related social needs services. Requires coordinated care organizations' governing bodies to include senior local health officials and county commissioners, when possible. Requires coordinated care organizations' community advisory councils to include local public health authority or local mental health authority representatives, when possible. Directs state agencies to allow local health departments to receive payment for various services.

Takes effect on the 91st day following adjournment sine die.

A BILL FOR AN ACT

Relating to medical assistance; creating new provisions; amending ORS 413.022, 414.152, 414.211, 414.572, 414.575, 414.577 and 414.581; and prescribing an effective date.

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

SECTION 1. ORS 413.022 is amended to read:

413.022. (1) As used in this section:

(a) "Downstream health outcome and quality measures" means:

(A) The sets of core quality measures for the Medicaid program that are published by the Centers for Medicare and Medicaid Services in accordance with 42 U.S.C. 1320b-9a and 1320b-9b; and

(B) If the sets of core quality measures for adults published by the Centers for Medicare and Medicaid Services do not include quality measures for oral health care for adults, quality measures of oral health care for adults adopted by the metrics and scoring subcommittee.

(b) "Upstream health outcome and quality measures" means quality measures that focus on the social determinants of health.

(2) There is created in the Health Plan Quality Metrics Committee a nine-member metrics and scoring subcommittee appointed by the Director of the Oregon Health Authority. The members of the subcommittee serve two-year terms and must include:

(a) Three members at large;

(b) Three individuals with expertise in health outcomes measures**, including one member of the Oregon Public Health Advisory Board with expertise in public health or population health data**; and

(c) Three representatives of coordinated care organizations.

(3) The subcommittee shall use a public process in accordance with ORS 192.610 to 192.705 that includes an opportunity for public comment to select the downstream health outcome and quality

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.

measures and a minimum of four upstream health outcome and quality measures applicable to services provided by coordinated care organizations.

(4) The Oregon Health Authority 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.

(5) The subcommittee shall update the health outcome and quality measures annually, if necessary, to conform to the latest sets of core quality measures published by the Centers for Medicare and Medicaid Services.

(6) 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.

(7) The authority and the Oregon Health Policy Board shall evaluate on a regular and ongoing basis the outcome and quality measures selected by the subcommittee under this section for members in each coordinated care organization and for members statewide.

(8) Members of the subcommittee 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 authority in the manner and amount provided in ORS 292.495.

SECTION 2. ORS 414.211 is amended to read:

414.211. (1) There is established a Medicaid Advisory Committee consisting of not more than 15 members appointed by the Governor.

(2) The committee shall be composed of:

(a) A physician licensed under ORS chapter 677;

(b) Two members of health care consumer groups that include Medicaid recipients;

(c) Two Medicaid recipients, one of whom shall be a person with a disability;

(d) The Director of the Oregon Health Authority or designee;

(e) The Director of Human Services or designee;

(f) Health care providers;

(g) Persons associated with health care organizations, including but not limited to coordinated care organizations under contract to the Medicaid program; [*and*]

(h) Professionals with experience in the provision of public health, behavioral health and health-related social needs services; and

[*(h)*] **(i)** Members of the general public.

(3) In making appointments, the Governor shall consult with appropriate professional and other interested organizations. All members appointed to the committee shall be familiar with the medical needs of low income persons.

(4) The term of office for each member shall be two years, but each member shall serve at the pleasure of the Governor.

(5) Members of the committee shall receive no compensation for their services but, subject to any applicable state law, shall be allowed actual and necessary travel expenses incurred in the

performance of their duties from the Oregon Health Authority Fund.

SECTION 3. ORS 414.572 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 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 413.022 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**;**

(G) When possible, at least one senior local health official designated by the counties served by the coordinated care organization, including a local health department official, a local public health administrator as defined in ORS 431.003 or a community mental health program director; and

(H) When possible, at least one county commissioner designated by the counties served by the coordinated care organization.

(p) If a coordinated care organization's governing body includes more than one senior local health official or county commissioner, a majority of the governing body may designate members to be ex officio members.

[*(p)*] **(q)** 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)*] **(r)** 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)*] **(s)** 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 primary 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 are employed only for health-related social needs services, such as housing supports, nutritional assistance and climate-related assistance, approved for the demonstration project under 42 U.S.C. 1315 by the Centers for Medicare and Medicaid Services.

SECTION 4. ORS 414.575 is amended to read:

414.575. (1) A coordinated care organization must have a community advisory council to ensure that the health care needs of the consumers and the community are being addressed. The council must:

(a) Include representatives of the community and of each county government served by the coordinated care organization, but consumer representatives must constitute a majority of the membership; [*and*]

(b) When possible, include representatives of the local public health authority as defined in ORS 431.003 and the local mental health authority as defined in ORS 430.630; and

[*(b)*] **(c)** Have its membership selected by a committee composed of equal numbers of county representatives from each county served by the coordinated care organization and members of the governing body of the coordinated care organization.

(2) The duties of the council include, but are not limited to:

(a) Identifying and advocating for preventive care practices to be utilized by the coordinated care organization;

(b) Overseeing a community health assessment and adopting a community health improvement

plan in accordance with ORS 414.577; and

(c) Annually publishing a report on the progress of the community health improvement plan.

(3) The community health improvement plan adopted by the council should describe the scope of the activities, services and responsibilities that the coordinated care organization will consider upon implementation of the plan. The activities, services and responsibilities defined in the plan shall include a plan and a strategy for integrating physical, behavioral and oral health care services and may include, but are not limited to:

(a) Analysis and development of public and private resources, capacities and metrics based on ongoing community health assessment activities and population health priorities;

(b) Health policy;

(c) System design;

(d) Outcome and quality improvement;

(e) Integration of service delivery; and

(f) Workforce development.

(4) The council shall meet at least once every three months. The council shall post a report of its meetings and discussions to the website of the coordinated care organization and other websites appropriate to keeping the community informed of the council's activities. The council, the governing body of the coordinated care organization or a designee of the council or governing body has discretion as to whether public comments received at meetings that are open to the public will be included in the reports posted to the website and, if so, which comments are appropriate for posting.

(5) If the regular council meetings are not open to the public and do not provide an opportunity for members of the public to provide written and oral comments, the council shall hold quarterly meetings:

(a) That are open to the public and attended by the members of the council;

(b) At which the council shall report on the activities of the coordinated care organization and the council;

(c) At which the council shall provide written reports on the activities of the coordinated care organization; and

(d) At which the council shall provide the opportunity for the public to provide written or oral comments.

(6) The coordinated care organization shall post to the organization's website contact information for, at a minimum, the chairperson, a member of the community advisory council or a designated staff member of the organization.

(7) Meetings of the council are not subject to ORS 192.610 to 192.705.

SECTION 5. ORS 414.577 is amended to read:

414.577. (1) A coordinated care organization shall collaborate with local public health authorities and hospitals located in areas served by the coordinated care organization to conduct a community health assessment and adopt a community health improvement plan, shared with and endorsed by the coordinated care organization, local public health authorities and hospitals, to serve as a strategic population health and health care services plan for the residents of the areas served by the coordinated care organization, local public health authorities and hospitals. The health improvement plan must include **aligned and coordinated** strategies for achieving shared **local** priorities.

(2) The coordinated care organization shall post the health improvement plan to the coordinated

care organization's website.

(3) The Oregon Health Authority may prescribe by rule requirements for health improvement plans and provide guidance for aligning the timelines for the development of the community health assessments and health improvement plans by coordinated care organizations, local public health authorities and hospitals.

SECTION 6. ORS 414.152 is amended to read:

414.152. To capitalize on the successful public health programs provided by local health departments**, which align and overlap with the work of coordinated care organizations,** and the sizable investment by state and local governments in the public health system, state agencies shall**:**

(1) Encourage agreements that allow local health departments and other publicly supported programs to continue to be the providers of those prevention and health promotion services now available, plus other maternal and child health services such as prenatal outreach and care, child health services and family planning services to women and children who become eligible for poverty level medical assistance program benefits pursuant to ORS 414.153**; and**

(2) Allow local health departments to receive payment for the services described in this section through a method negotiated by a local health department and a coordinated care organization that is appropriate for the type of services provided.

SECTION 7. ORS 414.581 is amended to read:

414.581. (1) The Tribal Advisory Council is established. The duties of the council are to:

(a) Serve as a channel of communication between the coordinated care organizations and Indian tribes in this state regarding the health of tribal communities; and

(b) Oversee the tribal liaisons in each coordinated care organization, described in ORS 414.572 [*(2)(r)*] **(2)(s)**, and work with coordinated care organizations.

(2) The council consists of members who are appointed by each Indian tribe in this state and one member appointed by the members of the council to represent the urban Indian health programs in this state that are operated by urban Indian organizations pursuant to 25 U.S.C. 1651.

(3) The term of office of each member of the council is four years, but a member serves at the pleasure of the Indian tribe that appointed the member. Before the expiration of the term of a member, the tribe that appointed the member shall appoint a successor whose term begins on January 1 next following. A member is eligible for reappointment. If there is a vacancy for any cause, the vacancy shall be filled by the appointing tribe to become immediately effective for the unexpired term.

(4) Members of the council are not entitled to compensation or reimbursement of expenses and serve as volunteers on the council.

(5) The council shall select one of its members as chairperson and another as vice chairperson, for terms and with duties and powers necessary for the performance of the functions of the offices as the council determines. The chairperson shall be responsible for the adoption of bylaws for the council.

(6) A majority of the members of the council constitutes a quorum for the transaction of business.

(7) The council shall meet at least once every three months at a time and place determined by the council. The council also may meet at other times and places specified by the call of the chairperson or of a majority of the members of the council.

(8) The Oregon Health Authority shall provide staff support to the council.

SECTION 8. The amendments to ORS 414.152 by section 6 of this 2025 Act apply to con-

tracts between a coordinated care organization and the Oregon Health Authority entered into, amended or renewed on or after the effective date of this 2025 Act.

SECTION 9. (1) The amendments to ORS 413.022, 414.211, 414.572 and 414.575 by sections 1 to 4 of this 2025 Act become operative on January 1, 2026.

(2) The Oregon Health Authority, the Governor and coordinated care organizations may take any action before the operative date specified in subsection (1) of this section that is necessary to enable the authority, the Governor and coordinated care organizations to exercise, on and after the operative date specified in subsection (1) of this section, all of the duties, functions and powers conferred on the authority, the Governor and coordinated care organizations by the amendments to ORS 413.022, 414.211, 414.572 and 414.575 by sections 1 to 4 of this 2025 Act.

SECTION 10. This 2025 Act takes effect on the 91st day after the date on which the 2025 regular session of the Eighty-third Legislative Assembly adjourns sine die.