A-Engrossed
Senate Bill 695

Ordered by the Senate April 10
Including Senate Amendments dated April 10

Sponsored by Senator REYNOLDS, Representatives GRAYBER, NERON; Senators ANDERSON, PATTERSON, STARR, Representatives NELSON, PHAM H (Presession filed.)

SUMMARY

The following summary is not prepared by the sponsors of the measure and is not a part of the body thereof subject to consideration by the Legislative Assembly. It is an editor's brief statement of the essential features of the measure. The statement includes a measure digest written in compliance with applicable readability standards.

Digest: The Act tells OHA and CCOs to make various changes designed to improve maternal and infant health. (Flesch Readability Score: 60.1).

[*Directs the Oregon Health Authority, for contracts entered into between the authority and a coordinated care organization, to establish terms and conditions designed to achieve transformational changes to maternal and infant health.*] **Requires the Oregon Health Authority and coordinated care organizations to develop and implement a whole-person maternal health model for medical assistance recipients.** Requires coordinated care organizations to partner with Early Learning Hubs **and federally qualified health centers** in adopting community health improvement plans. [*Directs the authority to require coordinated care organizations to spend a portion of any bonus payment on value-based payments to maternal health or early childhood providers.*] Directs the metrics and scoring subcommittee of the Health Plan Quality Metrics Committee to [*develop health equity milestones for pregnancy and early childhood*] **consider the need to prioritize equity-focused health outcome and quality measures relating to pregnancy and early childhood**. [*Extends the term of a contract entered into between the authority and a coordinated care organization to 10 years and directs the authority to review a coordinated care organization's performance after the initial five years.*]

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

A BILL FOR AN ACT

Relating to coordinated care organizations; creating new provisions; amending ORS 413.022, 414.577, 414.578 and 414.598; and prescribing an effective date.

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

SECTION 1. (1) As used in this section, "coordinated care organization" and "medical assistance" have the meanings given those terms in ORS 414.025.

(2) The Oregon Health Authority and a coordinated care organization shall develop and implement a whole-person maternal health model for recipients of medical assistance that includes:

(a) Comprehensive needs assessment and behavioral health risk screening during a pregnant recipient's first prenatal care visit;

(b) Interventions and supports for substance use disorder and other behavioral health needs;

(c) Providing a directory of local resources to help recipients apply for and obtain:

(A) Supplemental nutrition assistance;

(B) Women, Infants and Children Program benefits under ORS 413.500;

(C) Temporary assistance for needy families;

(D) The child tax credit under ORS 315.273;

(E) State and federal earned income tax credits; and

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.

(F) Other means-tested benefits available to low-income individuals;

(d) Maternity case management services;

(e) Doula support, peer support and enrollment in a nurse home visiting program, if needed;

(f) Connection to local parenting or child-focused organizations to develop a family success plan and receive other maternal and infant health supports;

(g) Tracking and monitoring of cesarean section births, postpartum care, chronic health conditions and tobacco cessation efforts;

(h) Contraception education, resources and support; and

(i) Coordination of efforts with a recipient's care team.

SECTION 2. ORS 414.577 and 414.578 are added to and made a part of ORS chapter 414.

SECTION 3. ORS 414.577 is amended to read:

414.577. (1) A coordinated care organization shall collaborate with local public health authorities**, Early Learning Hubs, federally qualified health centers** 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**, Early Learning Hubs, federally qualified health centers** 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**, Early Learning Hubs, federally qualified health centers** and hospitals. The health improvement plan must include strategies for achieving shared 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**, Early Learning Hubs, federally qualified health centers** and hospitals.

SECTION 4. ORS 414.578 is amended to read:

414.578. (1) A community health improvement plan adopted by a coordinated care organization and its community advisory council in accordance with ORS 414.577 shall include a component for addressing the health of children and youth in the areas served by the coordinated care organization including, to the extent practicable, a strategy and a plan for:

(a) Working with programs developed by the Early Learning Council, Early Learning Hubs, the Youth Development Council and the school health providers in the region; and

(b) Coordinating the effective and efficient delivery of health care to children and adolescents in the community.

(2) A community health improvement plan must be based on research, including research into adverse childhood experiences, and must identify funding sources and additional funding necessary to address the health needs of children and adolescents in the community and to meet the goals of the plan. The plan must also:

(a) Evaluate the adequacy of the existing school-based health resources including school-based health centers and school nurses to meet the specific pediatric and adolescent health care needs in the community;

(b) Make recommendations to improve the school-based health center and school nurse system, including the addition or improvement of electronic medical records and billing systems;

(c) Take into consideration whether integration of school-based health centers with the larger health system or system of community clinics would further advance the goals of the plan;

(d) Improve the integration of all services provided to meet the needs of children, adolescents and families**, including a focus on early learning, maternal care and the first 1,000 days of a child's life**;

(e) Focus on primary care, behavioral health and oral health; and

(f) Address promotion of health and prevention and early intervention in the treatment of children and adolescents.

(3) A coordinated care organization shall involve in the development of its community health improvement plan, school-based health centers, school nurses, school mental health providers and individuals representing:

(a) Programs developed by the Early Learning Council and Early Learning Hubs;

(b) Programs developed by the Youth Development Council in the region;

(c) The Healthy Start Family Support Services program in the region;

(d) The Cover All People program and other medical assistance programs;

(e) Relief nurseries in the region;

(f) Community health centers;

(g) Oral health care providers;

(h) Community mental health providers;

(i) Administrators of county health department programs that offer preventive health services to children;

(j) Hospitals in the region; and

(k) Other appropriate child and adolescent health program administrators.

(4) The Oregon Health Authority may provide incentive grants to coordinated care organizations for the purpose of contracting with individuals or organizations to help coordinate integration strategies identified in the community health improvement plan adopted by the community advisory council. The authority may also provide funds to coordinated care organizations to improve systems of services that will promote the implementation of the plan.

(5) Each coordinated care organization shall report to the authority, in the form and manner prescribed by the authority, on the progress of the integration strategies and implementation of the plan for working with the programs developed by the Early Learning Council, Early Learning Hubs, the Youth Development Council and school health care providers in the region, as part of the development and implementation of the community health improvement plan. The authority shall compile the information biennially and report the information to the Legislative Assembly by December 31 of each even-numbered year.

SECTION 5. ORS 414.598 is amended to read:

414.598. **(1) As used in this section, "maternal medical home" means a model of care that coordinates and aligns services to improve outcomes for mothers and their children.**

[*(1)*] **(2)** The Oregon Health Authority shall encourage coordinated care organizations to use alternative payment methodologies that:

(a) Reimburse providers on the basis of health outcomes and quality measures instead of the volume of care;

(b) Hold organizations and providers responsible for the efficient delivery of quality care;

(c) Reward good performance;

(d) Limit increases in medical costs; and

(e) Use payment structures that create incentives to:

(A) Promote prevention**, including investments in early childhood health**;

(B) Provide person centered care; and

(C) Reward comprehensive care coordination using delivery models such as patient centered primary care homes [*and*]**,** behavioral health homes **and maternal medical homes**.

[*(2)*] **(3)** The authority shall encourage coordinated care organizations to utilize alternative payment methodologies that move from a predominantly fee-for-service system to payment methods that base reimbursement on the quality rather than the quantity of services provided.

[*(3)*] **(4)** A coordinated care organization that participates in a national primary care medical home payment model, conducted by the Center for Medicare and Medicaid Innovation in accordance with 42 U.S.C. 1315a, that includes performance-based incentive payments for primary care, shall offer similar alternative payment methodologies to all patient centered primary care homes identified in accordance with ORS 413.259 that serve members of the coordinated care organization.

[*(4)*] **(5)** The authority shall assist and support coordinated care organizations in identifying cost-cutting measures.

[*(5)*] **(6)** If a service provided in a health care facility is not covered by Medicare because the service is related to a health care acquired condition, the cost of the service may not be:

(a) Charged by a health care facility or any health services provider employed by or with privileges at the facility, to a coordinated care organization, a patient or a third-party payer; or

(b) Reimbursed by a coordinated care organization.

[*(6)(a)*] **(7)(a)** Notwithstanding subsections [*(1) and*] (2) **and (3)** of this section, until July 1, 2014, a coordinated care organization that contracts with a Type A or Type B hospital or a rural critical access hospital, as described in ORS 442.470, shall reimburse the hospital fully for the cost of covered services based on the cost-to-charge ratio used for each hospital in setting the global payments to the coordinated care organization for the contract period.

(b) The authority shall base the global payments to coordinated care organizations that contract with rural hospitals described in this section on the most recent audited Medicare cost report for Oregon hospitals adjusted to reflect the Medicaid mix of services.

(c) The authority shall identify any rural hospital that would not be expected to remain financially viable if paid in a manner other than as prescribed in paragraphs (a) and (b) of this subsection based upon an evaluation by an actuary retained by the authority. On and after July 1, 2014, the authority may, on a case-by-case basis, require a coordinated care organization to continue to reimburse a rural hospital determined to be at financial risk, in the manner prescribed in paragraphs (a) and (b) of this subsection.

(d) This subsection does not prohibit a coordinated care organization and a hospital from mutually agreeing to reimbursement other than the reimbursement specified in paragraph (a) of this subsection.

(e) Hospitals reimbursed under paragraphs (a) and (b) of this subsection are not entitled to any additional reimbursement for services provided.

[*(7)*] **(8)** Notwithstanding subsections [*(1) and*] (2) **and (3)** of this section, coordinated care organizations must comply with federal requirements for payments to providers of Indian health services, including but not limited to the requirements of 42 U.S.C. 1396j and 42 U.S.C. 1396u-2(a)(2)(C).

SECTION 6. 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; and

(c) Three representatives of coordinated care organizations.

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

(b) In selecting the health outcome and quality measures described in paragraph (a) of this subsection, the subcommittee shall consider the need to prioritize equity-focused measures relating to pregnancy and early childhood.

(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 7. The amendments to ORS 414.577 and 414.578 by sections 3 and 4 of this 2025 Act apply to community health assessments conducted and community health improvement plans adopted on or after the effective date of this 2025 Act.

SECTION 8. 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.