Senate Bill 695

Sponsored by Senator REYNOLDS, Representatives GRAYBER, NERON; 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 **as introduced.** 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 coordinated care organizations to partner with Early Learning Hubs 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. 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, 414.572, 414.577, 414.578, 414.590, 414.591, 414.598 and 414.609; 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" has the meaning given that term in ORS 414.025.

(2) Beginning in 2026, for contracts entered into between the Oregon Health Authority and a coordinated care organization, the authority shall establish terms and conditions designed to achieve the following transformational changes by January 1, 2036:

(a) A coordinated care organization shall collaborate with community partners to ensure, to the extent allowable by federal law, that members of the coordinated care organization have access to safe, stable housing during pregnancy and for 12 months postpartum;

(b) A coordinated care organization shall develop plans to support the perinatal workforce, including doulas, community health workers as defined in ORS 414.025, peer support specialists as defined in ORS 414.025, behavioral health workers and lactation specialists;

(c) A coordinated care organization shall engage in workforce development by funding educational opportunities for students of secondary and postsecondary educational institutions or by partnering with public or private economic development organizations on provider recruitment or retention efforts; and

(d) A coordinated care organization shall develop and implement a whole-person maternal health model that includes:

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

(B) Interventions and supports for substance use disorder and other behavioral health

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.

needs;

(C) Assistance in applying for and obtaining:

(i) Supplemental nutrition assistance;

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

(iii) Temporary assistance for needy families;

(iv) The child tax credit under ORS 315.273;

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

(vi) 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 member's primary care provider.

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** 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** 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** 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** 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 414.572 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 en-

tering 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.

(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.

(s) Each coordinated care organization implements care coordination benefits for individuals residing in a correctional facility, to the extent allowable under ORS 411.447 and federal law.

(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 6. ORS 414.609, as amended by section 10, chapter 70, Oregon Laws 2024, is amended to read:

414.609. (1) A coordinated care organization that contracts with the Oregon Health Authority must maintain a network of providers, including but not limited to addiction treatment providers **and providers of health-related social needs services approved for the Medicaid demonstration project under section 1115 of the Social Security Act (42 U.S.C. 1315)**, sufficient in numbers and areas of practice and geographically distributed in a manner to ensure that the health services provided under the contract are reasonably accessible to members.

(2) The authority shall work with coordinated care organizations on developing strategies to augment the behavioral health provider network, with the goal that any member who needs behavioral health services can receive them within one week.

[*(2)*] **(3)** A member may transfer from one organization to another organization no more than once during each enrollment period.

SECTION 7. ORS 414.598 is amended to read:

414.598. **(1) As used in this section, "value-based payment" means payment to a provider that explicitly rewards the value that can be produced through the provision of health care services to coordinated care organization members.**

[*(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;

(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.

(3) For any bonus payment made to a coordinated care organization as a reward for achieving health outcome and quality measures, the authority shall require the coordinated care organization to spend a portion of the bonus payment on value-based payments to maternal health or early childhood providers.

[*(2)*] **(4)** 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)*] **(5)** 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)*] **(6)** The authority shall assist and support coordinated care organizations in identifying cost-cutting measures.

[*(5)*] **(7)** 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)*] **(8)(a)** Notwithstanding subsections [*(1) and*] (2) **and (4)** 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)*] **(9)** Notwithstanding subsections [*(1) and*] (2) **and (4)** 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 8. 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) 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**:**

(a) The downstream health outcome and quality measures [*and*]**;**

(b) A minimum of four upstream health outcome and quality measures applicable to services provided by coordinated care organizations**; and**

(c) Health equity milestones related to pregnancy and early childhood, such as maternal mortality rates and rates of conducting developmental screenings.

(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 9. ORS 414.590 is amended to read:

414.590. (1) As used in this section:

(a) "Benefit period" means a period of time, shorter than the five-year contract term, for which

specific terms and conditions in a contract between a coordinated care organization and the Oregon Health Authority are in effect.

(b) "Renew" means an agreement by a coordinated care organization to amend the terms or conditions of an existing contract for the next benefit period.

(2) A contract entered into between the authority and a coordinated care organization under ORS 414.572 (1):

(a) Shall be for a term of [*five*] **10** years;

(b) Except as provided in subsection [*(4)*] **(5)** of this section, may not be amended more than once in each 12-month period; and

(c) May be terminated by the authority if a coordinated care organization fails to meet outcome and quality measures specified in the contract or is otherwise in breach of the contract.

(3) After the initial five years of a contract entered into between the authority and a coordinated care organization under subsection (2)(a) of this section, the authority shall review the coordinated care organization's performance in a manner prescribed by the authority by rule, including a review of:

(a) The coordinated care organization's performance on quality measures for the preceding five years;

(b) The coordinated care organization's performance on external quality reviews under ORS 414.595 for the preceding five years; and

(c) The extent to which the coordinated care organization's community advisory council has been afforded the opportunity for meaningful participation.

[*(3)*] **(4)** This section does not prohibit the authority from allowing a coordinated care organization a reasonable amount of time in which to cure any failure to meet outcome and quality measures specified in the contract prior to the termination of the contract.

[*(4)*] **(5)** A contract entered into between the authority and a coordinated care organization may be amended:

(a) More than once in each 12-month period if:

(A) The authority and the coordinated care organization mutually agree to amend the contract; or

(B) Amendments are necessitated by changes in federal or state law.

(b) Once within the first eight months of the effective date of the contract if needed to adjust the global budget of a coordinated care organization, retroactive to the beginning of the calendar year, to take into account changes in the membership of the coordinated care organization or the health status of the coordinated care organization's members.

[*(5)*] **(6)** Except as provided in subsection [*(8)*] **(9)** of this section, the authority must give a coordinated care organization at least 60 days' advance notice of any amendments the authority proposes to existing contracts between the authority and the coordinated care organization.

[*(6)*] **(7)** Except as provided in subsection [*(4)(b)*] **(5)(b)** of this section, an amendment to a contract may apply retroactively only if:

(a) The amendment does not result in a claim by the authority for the recovery of amounts paid by the authority to the coordinated care organization prior to the date of the amendment; or

(b) The Centers for Medicare and Medicaid Services notifies the authority, in writing, that the amendment is a condition for approval of the contract by the Centers for Medicare and Medicaid Services.

[*(7)*] **(8)** If an amendment to a contract under subsection [*(6)(b)*] **(7)(b)** of this section or other

circumstances arise that result in a claim by the authority for the recovery of amounts previously paid to a coordinated care organization by the authority, the authority shall ensure that the recovery does not have a material adverse effect on the coordinated care organization's ability to maintain the required minimum amounts of risk-based capital.

[*(8)*] **(9)** No later than 134 days prior to the end of a benefit period, the authority shall provide to each coordinated care organization notice of the proposed changes to the terms and conditions of a contract, as will be submitted to the Centers for Medicare and Medicaid Services for approval, for the next benefit period.

[*(9)*] **(10)** A coordinated care organization must notify the authority of the coordinated care organization's refusal to renew a contract with the authority no later than 14 days after the authority provides the notice described in subsection [*(8)*] **(9)** of this section. Except as provided in subsections [*(10)*] **(11)** and [*(11)*] **(12)** of this section, a refusal to renew terminates the contract at the end of the benefit period.

[*(10)*] **(11)** The authority may require a contract to remain in force into the next benefit period and be amended as proposed by the authority until 90 days after the coordinated care organization has, in accordance with criteria prescribed by the authority:

(a) Notified each of its members and contracted providers of the termination of the contract;

(b) Provided to the authority a plan to transition its members to another coordinated care organization; and

(c) Provided to the authority a plan for closing out its coordinated care organization business.

[*(11)*] **(12)** The authority may waive compliance with the deadlines in subsections [*(9)*] **(10)** and [*(10)*] **(11)** of this section if the Director of the Oregon Health Authority finds that the waiver of the deadlines is consistent with the effective and efficient administration of the medical assistance program and the protection of medical assistance recipients.

SECTION 10. ORS 414.591 is amended to read:

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

(2)**(a)** The authority shall execute contracts with coordinated care organizations that meet the criteria adopted by the authority under ORS 414.572**, with special consideration given to the coordinated care organization's:**

(A) Performance on quality measures;

(B) Financial management; and

(C) Ability to implement new programs, including but not limited to the bridge program described in ORS 414.241, the Cover All People program established in ORS 414.231 and the health-related social needs services approved for the Medicaid demonstration project under section 1115 of the Social Security Act (42 U.S.C. 1315).

(b) Contracts under this subsection are not subject to ORS chapters 279A and 279B, except ORS 279A.250 to 279A.290 and 279B.235.

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

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

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

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

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

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

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

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

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

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

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

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

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

(9) Actions taken by providers, potential providers, contractors and bidders in specific accordance with this chapter in forming consortiums or in otherwise entering into contracts to provide

health care services shall be performed pursuant to state supervision and shall be considered to be conducted at the direction of this state, shall be considered to be lawful trade practices and may not be considered to be the transaction of insurance for purposes of the Insurance Code.

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

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

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

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

(a) Grievances and appeals; and

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

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

SECTION 11. Section 1 of this 2025 Act is repealed on January 2, 2037.

SECTION 12. (1) 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.

(2) The amendments to ORS 414.572, 414.598, 414.590, 414.591 and 414.609 by sections 5 to 7, 9 and 10 of this 2025 Act apply to contracts between a coordinated care organization and the Oregon Health Authority entered into, amended or renewed on or after the operative date specified in section 13 of this 2025 Act.

SECTION 13. (1) The amendments to ORS 414.609 by section 6 of this 2025 Act become operative on January 1, 2026.

(2) The Oregon Health Authority may take any action before the operative date specified in subsection (1) of this section that is necessary to enable the authority 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 by the amendments to ORS 414.609 by section 6 of this 2025 Act.

SECTION 14. 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.