

Requested by Senator STEINER HAYWARD

**PROPOSED AMENDMENTS TO  
SENATE BILL 934**

1 On page 1 of the printed bill, line 2, after “ORS” insert “243.105, 243.135,  
2 243.860, 243.866.”.

3 In line 3, after “743.010” insert “and sections 1, 2 and 5, chapter 575,  
4 Oregon Laws 2015”.

5 Delete lines 5 through 30 and delete pages 2 through 8 and insert:

6 **“SECTION 1.** ORS 414.625 is amended to read:

7 “414.625. (1) The Oregon Health Authority shall adopt by rule the quali-  
8 fication criteria and requirements for a coordinated care organization and  
9 shall integrate the criteria and requirements into each contract with a co-  
10 ordinated care organization. Coordinated care organizations may be local,  
11 community-based organizations or statewide organizations with community-  
12 based participation in governance or any combination of the two. Coordi-  
13 nated care organizations may contract with counties or with other public or  
14 private entities to provide services to members. The authority may not con-  
15 tract with only one statewide organization. A coordinated care organization  
16 may be a single corporate structure or a network of providers organized  
17 through contractual relationships. The criteria adopted by the authority un-  
18 der this section must include, but are not limited to, the coordinated care  
19 organization’s demonstrated experience and capacity for:

20 “(a) Managing financial risk and establishing financial reserves.

21 “(b) Meeting the following minimum financial requirements:

1 “(A) Maintaining restricted reserves of \$250,000 plus an amount equal to  
2 50 percent of the coordinated care organization’s total actual or projected  
3 liabilities above \$250,000.

4 “(B) Maintaining a net worth in an amount equal to at least five percent  
5 of the average combined revenue in the prior two quarters of the partic-  
6 ipating health care entities.

7 “(c) Operating within a fixed global budget **and:**

8 “(A) **By January 1, 2023, spending at least 12 percent of the global**  
9 **budget on primary care, as defined in section 2, chapter 575, Oregon**  
10 **Laws 2015; or**

11 “(B) **Participating in a national primary care medical home pay-**  
12 **ment model, conducted by the Center for Medicare and Medicaid In-**  
13 **novation in accordance with 42 U.S.C. 1315a, that includes**  
14 **performance-based incentive payments for primary care.**

15 “(d) Developing and implementing alternative payment methodologies that  
16 are based on health care quality and improved health outcomes.

17 “(e) Coordinating the delivery of physical health care, mental health and  
18 chemical dependency services, oral health care and covered long-term care  
19 services.

20 “(f) Engaging community members and health care providers in improving  
21 the health of the community and addressing regional, cultural, socioeconomic  
22 and racial disparities in health care that exist among the coordinated care  
23 organization’s members and in the coordinated care organization’s commu-  
24 nity.

25 “(2) In addition to the criteria specified in subsection (1) of this section,  
26 the authority must adopt by rule requirements for coordinated care organ-  
27 izations contracting with the authority so that:

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

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

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

8       “(d) Members receive comprehensive transitional care, including appro-  
9 priate follow-up, when entering and leaving an acute care facility or a long  
10 term care setting.

11       “(e) Members receive assistance in navigating the health care delivery  
12 system and in accessing community and social support services and statewide  
13 resources, including through the use of certified health care interpreters, as  
14 defined in ORS 413.550, community health workers and personal health  
15 navigators who meet competency standards established by the authority un-  
16 der ORS 414.665 or who are certified by the Home Care Commission under  
17 ORS 410.604.

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

22       “(g) Each coordinated care organization uses health information technol-  
23 ogy to link services and care providers across the continuum of care to the  
24 greatest extent practicable and if financially viable.

25       “(h) Each coordinated care organization complies with the safeguards for  
26 members described in ORS 414.635.

27       “(i) Each coordinated care organization convenes a community advisory  
28 council that meets the criteria specified in ORS 414.627.

29       “(j) Each coordinated care organization prioritizes working with members  
30 who have high health care needs, multiple chronic conditions, mental illness

1 or chemical dependency and involves those members in accessing and man-  
2 aging appropriate preventive, health, remedial and supportive care and ser-  
3 vices to reduce the use of avoidable emergency room visits and hospital  
4 admissions.

5 “(k) Members have a choice of providers within the coordinated care  
6 organization’s network and that providers participating in a coordinated care  
7 organization:

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

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

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

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

17 “(E) Include providers of specialty care.

18 “(F) Are selected by coordinated care organizations using universal ap-  
19 plication and credentialing procedures and objective quality information and  
20 are removed if the providers fail to meet objective quality standards.

21 “(G) Work together to develop best practices for culturally appropriate  
22 care and service delivery to reduce waste, reduce health disparities and im-  
23 prove the health and well-being of members.

24 “(L) Each coordinated care organization reports on outcome and quality  
25 measures adopted under ORS 414.638 and participates in the health care data  
26 reporting system established in ORS 442.464 and 442.466.

27 “(m) Each coordinated care organization uses best practices in the man-  
28 agement of finances, contracts, claims processing, payment functions and  
29 provider networks.

30 “(n) Each coordinated care organization participates in the learning

1 collaborative described in ORS 413.259 (3).

2 “(o) Each coordinated care organization has a governing body that in-  
3 cludes:

4 “(A) Persons that share in the financial risk of the organization who must  
5 constitute a majority of the governing body;

6 “(B) The major components of the health care delivery system;

7 “(C) At least two health care providers in active practice, including:

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

10 “(ii) A mental health or chemical dependency treatment provider;

11 “(D) At least two members from the community at large, to ensure that  
12 the organization’s decision-making is consistent with the values of the  
13 members and the community; and

14 “(E) At least one member of the community advisory council.

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

19 “(3) The authority shall consider the participation of area agencies and  
20 other nonprofit agencies in the configuration of coordinated care organiza-  
21 tions.

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

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

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

28 “(c) Allow more than one coordinated care organization to serve the ge-  
29 ographic area if necessary to optimize access and choice under this sub-  
30 section.

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

5 **“SECTION 2. Section 3 of this 2017 Act is added to and made a part  
6 of ORS chapter 413.**

7 **“SECTION 3. (1) As used in this section, ‘primary care’ has the  
8 meaning given that term in section 2, chapter 575, Oregon Laws 2015.**

9 **“(2) A coordinated care organization that spends less than 12 per-  
10 cent of its global budget on primary care shall submit to the Oregon  
11 Health Authority a plan to increase spending on primary care as a  
12 percentage of its global budget by at least one percent each year.**

13 **“SECTION 4. ORS 414.653 is amended to read:**

14 **“414.653. (1) The Oregon Health Authority shall encourage coordinated  
15 care organizations to use alternative payment methodologies that:**

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

18 **“(b) Hold organizations and providers responsible for the efficient deliv-  
19 ery of quality care;**

20 **“(c) Reward good performance;**

21 **“(d) Limit increases in medical costs; and**

22 **“(e) Use payment structures that create incentives to:**

23 **“(A) Promote prevention;**

24 **“(B) Provide person centered care; and**

25 **“(C) Reward comprehensive care coordination using delivery models such  
26 as patient centered primary care homes and behavioral health homes.**

27 **“(2) The authority shall encourage coordinated care organizations to uti-  
28 lize alternative payment methodologies that move from a predominantly fee-  
29 for-service system to payment methods that base reimbursement on the  
30 quality rather than the quantity of services provided.**

1       **“(3) A coordinated care organization that participates in a national**  
2 **primary care medical home payment model, conducted by the Center**  
3 **for Medicare and Medicaid Innovation in accordance with 42 U.S.C.**  
4 **1315a, that includes performance-based incentive payments for primary**  
5 **care, shall offer similar alternative payment methodologies to all pa-**  
6 **tient centered primary care homes identified in accordance with ORS**  
7 **413.259 that serve members of the coordinated care organization.**

8       ~~“(3)~~ (4) The authority shall assist and support coordinated care organ-  
9 izations in identifying cost-cutting measures.

10       ~~“(4)~~ (5) If a service provided in a health care facility is not covered by  
11 Medicare because the service is related to a health care acquired condition,  
12 the cost of the service may not be:

13       “(a) Charged by a health care facility or any health services provider  
14 employed by or with privileges at the facility, to a coordinated care organ-  
15 ization, a patient or a third-party payer; or

16       “(b) Reimbursed by a coordinated care organization.

17       ~~“(5)(a)~~ (6)(a) Notwithstanding subsections (1) and (2) of this section,  
18 until July 1, 2014, a coordinated care organization that contracts with a Type  
19 A or Type B hospital or a rural critical access hospital, as described in ORS  
20 442.470, shall reimburse the hospital fully for the cost of covered services  
21 based on the cost-to-charge ratio used for each hospital in setting the global  
22 payments to the coordinated care organization for the contract period.

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

27       “(c) The authority shall identify any rural hospital that would not be  
28 expected to remain financially viable if paid in a manner other than as pre-  
29 scribed in paragraphs (a) and (b) of this subsection based upon an evaluation  
30 by an actuary retained by the authority. On and after July 1, 2014, the au-

1 thority may, on a case-by-case basis, require a coordinated care organization  
2 to continue to reimburse a rural hospital determined to be at financial risk,  
3 in the manner prescribed in paragraphs (a) and (b) of this subsection.

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

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

9 “[6] (7) Notwithstanding subsections (1) and (2) of this section, coordi-  
10 nated care organizations must comply with federal requirements for pay-  
11 ments to providers of Indian health services, including but not limited to the  
12 requirements of 42 U.S.C. 1396j and 42 U.S.C. 1396u-2(a)(2)(C).

13 **“SECTION 5.** ORS 743.010 is amended to read:

14 “743.010. (1) In addition to all other powers of the Director of the De-  
15 partment of Consumer and Business Services with respect thereto, the di-  
16 rector may issue rules with respect to policy forms and health benefit plan  
17 forms described in ORS 742.005 (6)(a) and (b):

18 “[1] (a) Establishing minimum benefit standards;

19 “[2] (b) Requiring the ratio of benefits to premiums to be not less than  
20 a specified percentage in order to be considered reasonable, and requiring the  
21 periodic filing of data that will demonstrate the insurer’s compliance; [and]

22 “[3] (c) Establishing requirements intended to discourage duplication or  
23 overlapping of coverage and replacement, without regard to the advantage  
24 to policyholders, of existing policies by new policies; **and**

25 **“(d) Establishing requirements for carriers offering health benefit**  
26 **plans that spend less than 12 percent of premiums on payments for**  
27 **primary care to submit with each rate filing a plan to increase**  
28 **spending on payments for primary care as a percentage of premiums**  
29 **by at least one percent each plan year.**

30 **“(2) As used in this section, ‘primary care’ means family medicine,**

1 **general internal medicine, naturopathic medicine, obstetrics and gy-**  
2 **necology, pediatrics, general psychiatry or services provided by a na-**  
3 **tional primary care medical home payment model, conducted by the**  
4 **Center for Medicare and Medicaid Innovation in accordance with 42**  
5 **U.S.C. 1315a.**

6 **“SECTION 6. Section 7 of this 2017 Act is added to and made a part**  
7 **of the Insurance Code.**

8 **“SECTION 7. An insurer offering a health benefit plan, as defined**  
9 **in ORS 743B.005, that reimburses the costs of services provided by a**  
10 **national primary care medical home payment model, conducted by the**  
11 **Center for Medicare and Medicaid Innovation in accordance with 42**  
12 **U.S.C. 1315a, that includes performance-based incentive payments for**  
13 **primary care, shall offer similar alternative payment methodologies**  
14 **to reimburse the costs of services provided by patient centered primary**  
15 **care homes identified in accordance with ORS 413.259 that serve ben-**  
16 **eficiaries of the health benefit plan.**

17 **“SECTION 8. ORS 243.105 is amended to read:**

18 **“243.105. As used in ORS 243.105 to 243.285, unless the context requires**  
19 **otherwise:**

20 **“(1) ‘Benefit plan’ includes, but is not limited to:**

21 **“(a) Contracts for insurance or other benefits, including medical, dental,**  
22 **vision, life, disability and other health care recognized by state law, and re-**  
23 **lated services and supplies;**

24 **“(b) Comparable benefits for employees who rely on spiritual means of**  
25 **healing; and**

26 **“(c) Self-insurance programs managed by the Public Employees’ Benefit**  
27 **Board.**

28 **“(2) ‘Board’ means the Public Employees’ Benefit Board.**

29 **“(3) ‘Carrier’ means an insurance company or health care service con-**  
30 **tractor holding a valid certificate of authority from the Director of the De-**

1 department of Consumer and Business Services, or two or more companies or  
2 contractors acting together pursuant to a joint venture, partnership or other  
3 joint means of operation, or a board-approved guarantor of benefit plan  
4 coverage and compensation.

5 “(4)(a) ‘Eligible employee’ means an officer or employee of a state agency  
6 or local government who elects to participate in one of the group benefit  
7 plans described in ORS 243.135. The term includes, but is not limited to, state  
8 officers and employees in the exempt, unclassified and classified service, and  
9 state officers and employees, whether or not retired, who:

10 “(A) Are receiving a service retirement allowance, a disability retirement  
11 allowance or a pension under the Public Employees Retirement System or  
12 are receiving a service retirement allowance, a disability retirement allow-  
13 ance or a pension under any other retirement or disability benefit plan or  
14 system offered by the State of Oregon for its officers and employees;

15 “(B) Are eligible to receive a service retirement allowance under the  
16 Public Employees Retirement System and have reached earliest retirement  
17 age under ORS chapter 238;

18 “(C) Are eligible to receive a pension under ORS 238A.100 to 238A.250,  
19 and have reached earliest retirement age as described in ORS 238A.165; or

20 “(D) Are eligible to receive a service retirement allowance or pension  
21 under another retirement benefit plan or system offered by the State of  
22 Oregon and have attained earliest retirement age under the plan or system.

23 “(b) ‘Eligible employee’ does not include individuals:

24 “(A) Engaged as independent contractors;

25 “(B) Whose periods of employment in emergency work are on an inter-  
26 mittent or irregular basis;

27 “(C) Who are employed on less than half-time basis unless the individuals  
28 are employed in positions classified as job-sharing positions, unless the in-  
29 dividuals are defined as eligible under rules of the board;

30 “(D) Appointed under ORS 240.309;

1 “(E) Provided sheltered employment or make-work by the state in an em-  
2 ployment or industries program maintained for the benefit of such individ-  
3 uals;

4 “(F) Provided student health care services in conjunction with their en-  
5 rollment as students at a public university listed in ORS 352.002; or

6 “(G) Who are members of a collective bargaining unit that represents  
7 police officers or firefighters.

8 “(5) ‘Family member’ means an eligible employee’s spouse and any un-  
9 married child or stepchild within age limits and other conditions imposed  
10 by the board with regard to unmarried children or stepchildren.

11 “(6) ‘Local government’ means any city, county or special district in this  
12 state or any intergovernmental entity created under ORS chapter 190.

13 “(7) ‘Payroll disbursing officer’ means the officer or official authorized to  
14 disburse moneys in payment of salaries and wages of employees of a state  
15 agency or local government.

16 “(8) ‘Premium’ means the monthly or other periodic charge for a benefit  
17 plan.

18 “(9) ‘Primary care’ means family medicine, general internal medi-  
19 cine, naturopathic medicine, obstetrics and gynecology, pediatrics,  
20 general psychiatry or services provided by a national primary care  
21 medical home payment model, conducted by the Center for Medicare  
22 and Medicaid Innovation in accordance with 42 U.S.C. 1315a.

23 “[9] (10) ‘State agency’ means every state officer, board, commission,  
24 department or other activity of state government.

25 “**SECTION 9.** ORS 243.135, as amended by section 4, chapter 389, Oregon  
26 Laws 2015, is amended to read:

27 “243.135. (1) Notwithstanding any other benefit plan contracted for and  
28 offered by the Public Employees’ Benefit Board, the board shall contract for  
29 a health benefit plan or plans best designed to meet the needs and provide  
30 for the welfare of eligible employees, the state and the local governments.

1 In considering whether to enter into a contract for a plan, the board shall  
2 place emphasis on:

- 3 “(a) Employee choice among high quality plans;
- 4 “(b) A competitive marketplace;
- 5 “(c) Plan performance and information;
- 6 “(d) Employer flexibility in plan design and contracting;
- 7 “(e) Quality customer service;
- 8 “(f) Creativity and innovation;
- 9 “(g) Plan benefits as part of total employee compensation;
- 10 “(h) The improvement of employee health; and
- 11 “(i) Health outcome and quality measures, described in ORS 413.017 (4),  
12 that are reported by the plan.

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

17 “(3) Where appropriate for a contracted and offered health benefit plan,  
18 the board shall provide options under which an eligible employee may ar-  
19 range coverage for family members.

20 “(4) Payroll deductions for costs that are not payable by the state or a  
21 local government may be made upon receipt of a signed authorization from  
22 the employee indicating an election to participate in the plan or plans se-  
23 lected and the deduction of a certain sum from the employee’s pay.

24 “(5) In developing any health benefit plan, the board may provide an op-  
25 tion of additional coverage for eligible employees and their family members  
26 at an additional cost or premium.

27 “(6) Transfer of enrollment from one plan to another shall be open to all  
28 eligible employees and their family members under rules adopted by the  
29 board. Because of the special problems that may arise in individual instances  
30 under comprehensive group practice plan coverage involving acceptable

1 provider-patient relations between a particular panel of providers and par-  
2 ticular eligible employees and their family members, the board shall provide  
3 a procedure under which any eligible employee may apply at any time to  
4 substitute a health service benefit plan for participation in a comprehensive  
5 group practice benefit plan.

6 “(7) The board shall evaluate a benefit plan that serves a limited ge-  
7 ographic region of this state according to the criteria described in subsection  
8 (1) of this section.

9 “(8) **By January 1, 2023, the board shall spend at least 12 percent of**  
10 **its total expenditures in self-insured health benefit plans on payments**  
11 **for primary care.**

12 “(9) **No later than February 1 of each year, the board shall report**  
13 **to the Legislative Assembly on the board’s progress toward achieving**  
14 **the target of spending at least 12 percent of total expenditures in**  
15 **self-insured health benefit plans on payments for primary care.**

16 “**SECTION 10.** ORS 243.860 is amended to read:

17 “243.860. As used in ORS 243.860 to 243.886, unless the context requires  
18 otherwise:

19 “(1) ‘Benefit plan’ includes but is not limited to:

20 “(a) Contracts for insurance or other benefits, including medical, dental,  
21 vision, life, disability and other health care recognized by state law, and re-  
22 lated services and supplies;

23 “(b) Self-insurance programs managed by the Oregon Educators Benefit  
24 Board; and

25 “(c) Comparable benefits for employees who rely on spiritual means of  
26 healing.

27 “(2) ‘Carrier’ means an insurance company or health care service con-  
28 tractor holding a valid certificate of authority from the Director of the De-  
29 partment of Consumer and Business Services, or two or more companies or  
30 contractors acting together pursuant to a joint venture, partnership or other

1 joint means of operation, or a board-approved provider or guarantor of ben-  
2 efit plan coverage and compensation.

3 “(3) ‘District’ means a common school district, a union high school dis-  
4 trict, an education service district, as defined in ORS 334.003, or a commu-  
5 nity college district, as defined in ORS 341.005.

6 “(4)(a) ‘Eligible employee’ includes:

7 “(A) An officer or employee of a district or a local government who elects  
8 to participate in one of the benefit plans described in ORS 243.864 to 243.874;  
9 and

10 “(B) An officer or employee of a district or a local government, whether  
11 or not retired, who:

12 “(i) Is receiving a service retirement allowance, a disability retirement  
13 allowance or a pension under the Public Employees Retirement System or is  
14 receiving a service retirement allowance, a disability retirement allowance  
15 or a pension under any other retirement or disability benefit plan or system  
16 offered by the district or local government for its officers and employees;

17 “(ii) Is eligible to receive a service retirement allowance under the Public  
18 Employees Retirement System and has reached earliest service retirement  
19 age under ORS chapter 238;

20 “(iii) Is eligible to receive a pension under ORS 238A.100 to 238A.250 and  
21 has reached earliest retirement age as described in ORS 238A.165; or

22 “(iv) Is eligible to receive a service retirement allowance or pension under  
23 any other retirement benefit plan or system offered by the district or local  
24 government and has attained earliest retirement age under the plan or sys-  
25 tem.

26 “(b) Except as provided in paragraph (a)(B) of this subsection, ‘eligible  
27 employee’ does not include an individual:

28 “(A) Engaged as an independent contractor;

29 “(B) Whose periods of employment in emergency work are on an inter-  
30 mittent or irregular basis; or

1 “(C) Who is employed on less than a half-time basis unless the individual  
2 is employed in a position classified as a job-sharing position or unless the  
3 individual is defined as eligible under rules of the Oregon Educators Benefit  
4 Board or under a collective bargaining agreement.

5 “(5) ‘Family member’ means an eligible employee’s spouse or domestic  
6 partner and any unmarried child or stepchild of an eligible employee within  
7 age limits and other conditions imposed by the Oregon Educators Benefit  
8 Board with regard to unmarried children or stepchildren.

9 “(6) ‘Local government’ means any city, county or special district in this  
10 state.

11 “(7) ‘Payroll disbursing officer’ means the officer or official authorized to  
12 disburse moneys in payment of salaries and wages of officers and employees  
13 of a district or a local government.

14 “(8) ‘Premium’ means the monthly or other periodic charge, including  
15 administrative fees of the Oregon Educators Benefit Board, for a benefit  
16 plan.

17 “(9) **‘Primary care’ means family medicine, general internal medi-**  
18 **cine, naturopathic medicine, obstetrics and gynecology, pediatrics,**  
19 **general psychiatry or services provided by a national primary care**  
20 **medical home payment model, conducted by the Center for Medicare**  
21 **and Medicaid Innovation in accordance with 42 U.S.C. 1315a.**

22 “**SECTION 11.** ORS 243.866, as amended by section 5, chapter 389, Oregon  
23 Laws 2015, is amended to read:

24 “243.866. (1) The Oregon Educators Benefit Board shall contract for ben-  
25 efit plans best designed to meet the needs and provide for the welfare of el-  
26 igible employees, the districts and local governments. In considering whether  
27 to enter into a contract for a benefit plan, the board shall place emphasis  
28 on:

29 “(a) Employee choice among high-quality plans;

30 “(b) Encouragement of a competitive marketplace;

1       “(c) Plan performance and information;  
2       “(d) District and local government flexibility in plan design and con-  
3       tracting;  
4       “(e) Quality customer service;  
5       “(f) Creativity and innovation;  
6       “(g) Plan benefits as part of total employee compensation;  
7       “(h) Improvement of employee health; and  
8       “(i) Health outcome and quality measures, described in ORS 413.017 (4),  
9       that are reported by the plan.

10       “(2) The board may approve more than one carrier for each type of benefit  
11       plan offered, but the board shall limit the number of carriers to a number  
12       consistent with adequate service to eligible employees and family members.

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

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

21       “(5) In developing any benefit plan, the board may provide an option of  
22       additional coverage for eligible employees and family members at an addi-  
23       tional premium.

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

1 for participation in a comprehensive group practice benefit plan.

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

6 “(8) The board shall evaluate a benefit plan that serves a limited ge-  
7 ographic region of this state according to the criteria described in subsection  
8 (1) of this section.

9 “(9) **By January 1, 2023, the board shall spend at least 12 percent of**  
10 **its total expenditures in self-insured health benefit plans on payments**  
11 **for primary care.**

12 “(10) **No later than February 1 of each year, the board shall report**  
13 **to the Legislative Assembly on the board’s progress toward achieving**  
14 **the target of spending at least 12 percent of total expenditures on**  
15 **payments for primary care.**

16 “**SECTION 12.** Section 1, chapter 575, Oregon Laws 2015, is amended to  
17 read:

18 “**Sec. 1.** (1) As used in this section:

19 “(a) ‘Carrier’ means an insurer that offers a health benefit plan, as de-  
20 fined in ORS [743.730] **743B.005.**

21 “(b) ‘Prominent carrier’ means:

22 “(A) A carrier with annual premium income at a threshold, **of no less**  
23 **than \$50 million**, established by the Department of Consumer and Business  
24 Services by rule.

25 “(B) The Public Employees’ Benefit Board.

26 “(C) The Oregon Educators Benefit Board.

27 “(2) All prominent carriers shall, and carriers other than prominent car-  
28 riers may, report to the Department of Consumer and Business Services, no  
29 later than December 31[, 2015] **of each year**, the proportion of the carrier’s  
30 total medical expenses that are allocated to primary care.

1 “(3) The department shall share with the Oregon Health Authority the  
2 information reported so that the authority may prepare the evaluation and  
3 report described in section 2, *[of this 2015 Act]* **chapter 575, Oregon Laws**  
4 **2015.**

5 “(4) The department, in collaboration with the authority, shall adopt rules  
6 prescribing the primary care services for which costs must be reported under  
7 subsection (2) of this section.

8 **“SECTION 13.** Section 2, chapter 575, Oregon Laws 2015, is amended to  
9 read:

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

11 “(a) ‘Carrier’ means an insurer that offers a health benefit plan, as de-  
12 fined in ORS 743B.005.

13 “(b) ‘Coordinated care organization’ has the meaning given that term in  
14 ORS 414.025.

15 “(c) ‘Primary care’ means family medicine, general internal medicine,  
16 naturopathic medicine, obstetrics and gynecology, pediatrics, *[or]* general  
17 psychiatry **or services provided by a national primary care medical**  
18 **home payment model, conducted by the Center for Medicare and**  
19 **Medicaid Innovation in accordance with 42 U.S.C. 1315a.**

20 “(d) ‘Primary care provider’ includes:

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

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

26 “(2)(a) The Oregon Health Authority shall convene a primary care pay-  
27 ment reform collaborative to *[advise and assist the authority in developing a*  
28 *Primary Care Transformation Initiative to develop and share best practices in*  
29 *technical assistance and methods of reimbursement that direct greater health*  
30 *care resources and investments toward supporting and facilitating health care*

1 *innovation and care improvement in primary care.] advise and assist in the*  
2 **implementation of a Primary Care Transformation Initiative to:**

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

5 **“(i) Increase the investment in primary care;**

6 **“(ii) Align primary care reimbursement by all purchasers of care;**  
7 **and**

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

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

12 **“(C) Provide technical assistance to clinics and payers in imple-**  
13 **menting the initiative;**

14 **“(D) Aggregate the data from and align the metrics used in the in-**  
15 **itiative with the work of the Health Plan Quality Metrics Committee**  
16 **established in ORS 413.017;**

17 **“(E) Facilitate the integration of primary care behavioral and**  
18 **physical health care; and**

19 **“(F) Ensure that the goals of the initiative are met by December**  
20 **31, 2027.**

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

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

24 **“(a) Primary care providers;**

25 **“(b) Health care consumers;**

26 **“(c) Experts in primary care contracting and reimbursement;**

27 **“(d) Independent practice associations;**

28 **“(e) Behavioral health treatment providers;**

29 **“(f) Third party administrators;**

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

1 “(h) The Department of Consumer and Business Services;

2 “(i) Carriers;

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

5 “(k) A statewide organization representing federally qualified health cen-  
6 ters;

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

8 “(m) A statewide professional association for family physicians;

9 “(n) A statewide professional association for physicians;

10 “(o) A statewide professional association for nurses; and

11 “(p) The Centers for Medicare and Medicaid Services.

12 “(4) [*The authority shall convene the primary care payment reform*  
13 *collaborative no later than October 1, 2015.*] **The primary care payment**  
14 **reform collaborative shall annually report to the Oregon Health Policy**  
15 **Board and to the Legislative Assembly on the achievement of the pri-**  
16 **mary care spending targets in ORS 414.625 and 743.010 and the imple-**  
17 **mentation of the Primary Care Transformation Initiative.**

18 “(5) A coordinated care organization shall report to the authority, no  
19 later than December 31[, 2015] **of each year**, the proportion of the  
20 organization’s total medical costs that are allocated to primary care.

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

24 **“SECTION 14.** ORS 414.625, as amended by section 1 of this 2017 Act, is  
25 amended to read:

26 “414.625. (1) The Oregon Health Authority shall adopt by rule the quali-  
27 fication criteria and requirements for a coordinated care organization and  
28 shall integrate the criteria and requirements into each contract with a co-  
29 ordinated care organization. Coordinated care organizations may be local,  
30 community-based organizations or statewide organizations with community-

1 based participation in governance or any combination of the two. Coordi-  
2 nated care organizations may contract with counties or with other public or  
3 private entities to provide services to members. The authority may not con-  
4 tract with only one statewide organization. A coordinated care organization  
5 may be a single corporate structure or a network of providers organized  
6 through contractual relationships. The criteria adopted by the authority un-  
7 der this section must include, but are not limited to, the coordinated care  
8 organization’s demonstrated experience and capacity for:

9 “(a) Managing financial risk and establishing financial reserves.

10 “(b) Meeting the following minimum financial requirements:

11 “(A) Maintaining restricted reserves of \$250,000 plus an amount equal to  
12 50 percent of the coordinated care organization’s total actual or projected  
13 liabilities above \$250,000.

14 “(B) Maintaining a net worth in an amount equal to at least five percent  
15 of the average combined revenue in the prior two quarters of the partic-  
16 ipating health care entities.

17 “(c) Operating within a fixed global budget and:

18 “(A) [*By January 1, 2023,*] Spending at least 12 percent of the global  
19 budget on primary care[, *as defined in section 2, chapter 575, Oregon Laws*  
20 *2015*] **as defined by the authority by rule**; or

21 “(B) Participating in a national primary care medical home payment  
22 model, conducted by the Center for Medicare and Medicaid Innovation in  
23 accordance with 42 U.S.C. 1315a, that includes performance-based incentive  
24 payments for primary care.

25 “(d) Developing and implementing alternative payment methodologies that  
26 are based on health care quality and improved health outcomes.

27 “(e) Coordinating the delivery of physical health care, mental health and  
28 chemical dependency services, oral health care and covered long-term care  
29 services.

30 “(f) Engaging community members and health care providers in improving

1 the health of the community and addressing regional, cultural, socioeconomic  
2 and racial disparities in health care that exist among the coordinated care  
3 organization’s members and in the coordinated care organization’s commu-  
4 nity.

5 “(2) In addition to the criteria specified in subsection (1) of this section,  
6 the authority must adopt by rule requirements for coordinated care organ-  
7 izations contracting with the authority so that:

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

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

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

18 “(d) Members receive comprehensive transitional care, including appro-  
19 priate follow-up, when entering and leaving an acute care facility or a long  
20 term care setting.

21 “(e) Members receive assistance in navigating the health care delivery  
22 system and in accessing community and social support services and statewide  
23 resources, including through the use of certified health care interpreters, as  
24 defined in ORS 413.550, community health workers and personal health  
25 navigators who meet competency standards established by the authority un-  
26 der ORS 414.665 or who are certified by the Home Care Commission under  
27 ORS 410.604.

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

1 populations.

2 “(g) Each coordinated care organization uses health information technol-  
3 ogy to link services and care providers across the continuum of care to the  
4 greatest extent practicable and if financially viable.

5 “(h) Each coordinated care organization complies with the safeguards for  
6 members described in ORS 414.635.

7 “(i) Each coordinated care organization convenes a community advisory  
8 council that meets the criteria specified in ORS 414.627.

9 “(j) Each coordinated care organization prioritizes working with members  
10 who have high health care needs, multiple chronic conditions, mental illness  
11 or chemical dependency and involves those members in accessing and man-  
12 aging appropriate preventive, health, remedial and supportive care and ser-  
13 vices to reduce the use of avoidable emergency room visits and hospital  
14 admissions.

15 “(k) Members have a choice of providers within the coordinated care  
16 organization’s network and that providers participating in a coordinated care  
17 organization:

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

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

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

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

27 “(E) Include providers of specialty care.

28 “(F) Are selected by coordinated care organizations using universal ap-  
29 plication and credentialing procedures and objective quality information and  
30 are removed if the providers fail to meet objective quality standards.

1 “(G) Work together to develop best practices for culturally appropriate  
2 care and service delivery to reduce waste, reduce health disparities and im-  
3 prove the health and well-being of members.

4 “(L) Each coordinated care organization reports on outcome and quality  
5 measures adopted under ORS 414.638 and participates in the health care data  
6 reporting system established in ORS 442.464 and 442.466.

7 “(m) Each coordinated care organization uses best practices in the man-  
8 agement of finances, contracts, claims processing, payment functions and  
9 provider networks.

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

12 “(o) Each coordinated care organization has a governing body that in-  
13 cludes:

14 “(A) Persons that share in the financial risk of the organization who must  
15 constitute a majority of the governing body;

16 “(B) The major components of the health care delivery system;

17 “(C) At least two health care providers in active practice, including:

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

20 “(ii) A mental health or chemical dependency treatment provider;

21 “(D) At least two members from the community at large, to ensure that  
22 the organization’s decision-making is consistent with the values of the  
23 members and the community; and

24 “(E) At least one member of the community advisory council.

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

29 “(3) The authority shall consider the participation of area agencies and  
30 other nonprofit agencies in the configuration of coordinated care organiza-

1 tions.

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

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

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

8 “(c) Allow more than one coordinated care organization to serve the ge-  
9 ographic area if necessary to optimize access and choice under this sub-  
10 section.

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

15 **“SECTION 15.** Section ORS 743.010, as amended by section 5 of this 2017  
16 Act is amended to read:

17 “743.010. (1) In addition to all other powers of the Director of the De-  
18 partment of Consumer and Business Services with respect thereto, the di-  
19 rector may issue rules with respect to policy forms and health benefit plan  
20 forms described in ORS 742.005 (6)(a) and (b):

21 “(a) Establishing minimum benefit standards;

22 “(b) Requiring the ratio of benefits to premiums to be not less than a  
23 specified percentage in order to be considered reasonable, and requiring the  
24 periodic filing of data that will demonstrate the insurer’s compliance;

25 “(c) Establishing requirements intended to discourage duplication or  
26 overlapping of coverage and replacement, without regard to the advantage  
27 to policyholders, of existing policies by new policies; and

28 “(d) Establishing requirements for carriers offering health benefit plans  
29 [*that spend less than*] **to spend at least** 12 percent of premiums on payments  
30 for primary care [*to submit with each rate filing a plan to increase spending*]

1 *on payments for primary care as a percentage of premiums by at least one*  
2 *percent each plan year].*

3 “(2) As used in this section, ‘primary care’ means family medicine, general  
4 internal medicine, naturopathic medicine, obstetrics and gynecology,  
5 pediatrics, general psychiatry or services provided by a national primary care  
6 medical home payment model, conducted by the Center for Medicare and  
7 Medicaid Innovation in accordance with 42 U.S.C. 1315a.

8 **“SECTION 16.** ORS 243.135, as amended by section 9 of this 2017 Act is  
9 amended to read:

10 “243.135. (1) Notwithstanding any other benefit plan contracted for and  
11 offered by the Public Employees’ Benefit Board, the board shall contract for  
12 a health benefit plan or plans best designed to meet the needs and provide  
13 for the welfare of eligible employees, the state and the local governments.  
14 In considering whether to enter into a contract for a plan, the board shall  
15 place emphasis on:

16 “(a) Employee choice among high quality plans;

17 “(b) A competitive marketplace;

18 “(c) Plan performance and information;

19 “(d) Employer flexibility in plan design and contracting;

20 “(e) Quality customer service;

21 “(f) Creativity and innovation;

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

23 “(h) The improvement of employee health; and

24 “(i) Health outcome and quality measures, described in ORS 413.017 (4),  
25 that are reported by the plan.

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

30 “(3) Where appropriate for a contracted and offered health benefit plan,

1 the board shall provide options under which an eligible employee may ar-  
2 range coverage for family members.

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

7 “(5) In developing any health benefit plan, the board may provide an op-  
8 tion of additional coverage for eligible employees and their family members  
9 at an additional cost or premium.

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

19 “(7) The board shall evaluate a benefit plan that serves a limited ge-  
20 ographic region of this state according to the criteria described in subsection  
21 (1) of this section.

22 “(8) *[By January 1, 2023, the board shall spend at least 12 percent of its*  
23 *total expenditures in self-insured health benefit plans on payments for primary*  
24 *care]* **If the board spends less than 12 percent of its total expenditures**  
25 **on self-insured health benefit plans on payments for primary care, the**  
26 **board shall implement a plan for increasing the percentage of total**  
27 **expenditures spent on payments for primary care by at least one per-**  
28 **cent each year.**

29 “(9) No later than February 1 of each year, the board shall report to the  
30 Legislative Assembly on **any plan implemented under subsection (8) of**

1 **this section and on** the board’s progress toward achieving the target of  
2 spending at least 12 percent of total expenditures in self-insured health ben-  
3 efit plans on payments for primary care.

4 **SECTION 17.** ORS 243.866, as amended by section 11 of this 2017 Act is  
5 amended to read:

6 “243.866. (1) The Oregon Educators Benefit Board shall contract for ben-  
7 efit plans best designed to meet the needs and provide for the welfare of el-  
8 igible employees, the districts and local governments. In considering whether  
9 to enter into a contract for a benefit plan, the board shall place emphasis  
10 on:

- 11 “(a) Employee choice among high-quality plans;
- 12 “(b) Encouragement of a competitive marketplace;
- 13 “(c) Plan performance and information;
- 14 “(d) District and local government flexibility in plan design and con-  
15 tracting;
- 16 “(e) Quality customer service;
- 17 “(f) Creativity and innovation;
- 18 “(g) Plan benefits as part of total employee compensation;
- 19 “(h) Improvement of employee health; and
- 20 “(i) Health outcome and quality measures, described in ORS 413.017 (4),  
21 that are reported by the plan.

22 “(2) The board may approve more than one carrier for each type of benefit  
23 plan offered, but the board shall limit the number of carriers to a number  
24 consistent with adequate service to eligible employees and family members.

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

28 “(4) A district or a local government shall provide that payroll deductions  
29 for benefit plan costs that are not payable by the district or local govern-  
30 ment may be made upon receipt of a signed authorization from the employee

1 indicating an election to participate in the benefit plan or plans selected and  
2 allowing the deduction of those costs from the employee's pay.

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

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

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

18 “(8) The board shall evaluate a benefit plan that serves a limited ge-  
19 ographic region of this state according to the criteria described in subsection  
20 (1) of this section.

21 “(9) *[By January 1, 2023, the board shall spend at least 12 percent of its*  
22 *total expenditures in self-insured health benefit plans on payments for primary*  
23 *care]* **If the board spends less than 12 percent of its total expenditures**  
24 **on self-insured health benefit plans on payments for primary care, the**  
25 **board shall implement a plan for increasing the percentage of total**  
26 **expenditures spent on payments for primary care by at least one per-**  
27 **cent each year.**

28 “(10) No later than February 1 of each year, the board shall report to the  
29 Legislative Assembly on **any plan implemented under subsection (9) of**  
30 **this section and on** the board's progress toward achieving the target of

1 spending at least 12 percent of total expenditures on payments for primary  
2 care.

3 **“SECTION 18. The amendments to ORS 743.010 by section 5 of this**  
4 **2017 Act apply to rates filed with the Department of Consumer and**  
5 **Business Services for approval on or after the effective date of this**  
6 **2017 Act.**

7 **“SECTION 19. Section 5, chapter 575, Oregon Laws 2015, as amended by**  
8 **section 8, chapter 26, Oregon Laws 2016, is amended to read:**

9 **“Sec. 5. (1) Sections 1[, 2 and] to 4, chapter 575, Oregon Laws 2015, are**  
10 **repealed on December 31, [2018] 2027.**

11 **“[(2) Section 3, chapter 575, Oregon Laws 2015, is repealed on January 2,**  
12 **2020.]**

13 **“(2) Section 3 of this 2017 Act is repealed on December 31, 2027.**

14 **“SECTION 20. Section 3 of this 2017 Act and the amendments to**  
15 **ORS 414.625, 243.135, 243.866 and 743.010 by sections 14 to 17 of this 2017**  
16 **Act become operative on January 1, 2023.”.**

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