# Oregon Revised Statutes Related to CCOs:

## **Background**

During the 7/17 meeting with CLHO, Rep. Nosse requested proposals for revisions to the [Oregon Revised Statutes Related to CCOs.docx](https://washcoor-my.sharepoint.com/%3Aw%3A/g/personal/laura_daily_co_washington_or_us/EXUKlFcExI5AmJzQD-dOunIBsOB7WTOg81w2GVd47ctaBg?e=eccOk5) for CCO 3.0. He will be holding a “salon” for CCO partners on August 19th and has requested proposed revisions and suggestions by August 9th. Washington County identified multiple areas of need while completing the CCO 3.0 Needs Assessment and talking points. These are listed below and cross-walked with the relevant ORSs (the full language from the ORSs is listed below that).

### **Request/Considerations**

Please review the suggestions below and provide feedback on the ideas and language. The key statutes and potential changes I see are in the table below, but I’ve listed the full language for each statute below the table. Please review the full language, as well, and make suggestions where you see additional changes.

* Please keep in mind that everything we submit will be public.
* Because our BOC has not approved any official recommendations from Washington County, these are framed as suggestions and ideas for Rep. Nosse to explore.
* What we submit on 8/9 to Rep. Nosse does not need to be specific, but the submission form does request we cite statute.
* To acknowledge our positive partners with CCOs AND address areas of need, we are looking for suggestions and revisions that will align systems and be of clear benefit to both counties and CCOs (and will bring about the change we want without being overly prescriptive or introducing ideas that will get pushback from CCOs broadly).
* These are public health-focused suggestions, but there is room to add language for county HHS and Housing broadly – please feel free to add this.

### **Crosswalk with Washington County Recommendations**

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| --- | --- | --- | --- |
| **Need Identified by Washington County** | **Relevant Statutes** | **Possible language change** | **Justification (include description of how solution will improve care or lower costs)** |
| **Revise funding agreements:** Additional funding from the global budget is needed to cover the comprehensive administration of programs beyond direct services. Current legislation also allows CCOs to enter into unfunded agreements. Revisit [ORS 414.153](https://oregon.public.law/statutes/ors_414.153) to ensure Counties (e.g., Public Health, Behavioral Health, Housing) are equitably funded. | 414.152 (Duty of state agencies to work with local health departments) | “...state agencies shall ~~encourage~~ **require** agreements that allow local health departments and other publicly supported programs to continue to be the providers of those prevention and health promotion services now available...” | LPHAs provide direct and population-level services that keep people healthy throughout their lives and reduce the overall cost of health care. However, **there are no requirements that CCOs fund or support these existing programs. This risks duplication and fragmentation of services.** |
| 414.153 (Services provided by local health departments) | 1. “~~authorization of payment for point of contact~~reasonable and sufficient for services in the following categories…
2. “ for ~~authorization of and~~reasonable and sufficient payment for services in the following categories…”

Add (as either 1d and 1e or 3g and 3h): “Primary substance use prevention programs, education, and services.“Chronic disease prevention programs, education, and services.”  | LPHAs need a reliable, sustained funding source for the services they provide to the Medicaid-covered population and for the population health services that contribute to community-level health outcomes. CCOs have a variety of ways to cover the cost of services and distribute funds in the community. However, these do not cover the administrative workload and true staffing costs (benefits, education). In a fee-for-service model, there are limits to what we can quantify for reimbursement.Just a 10% increase in Oregon public health departments’ per capita spending would link to: * Lowering infant mortality by an estimated 15 fewer infant deaths each year
* Lowering diabetes deaths by an estimated 16 fewer diabetes death each year
* Lowering heart disease deaths by an estimated 202 fewer heart disease deaths each year
* Lowering cancer deaths by an estimated 88 fewer cancer deaths each year.
* Solet, D., & Boles, M. (2016). The health and economic benefits of public health modernization in Oregon. Oregon Health Authority Program Design and Evaluation Services. Retrieved from <https://sharedsystems.dhsoha.state.or.us/DHSForms/Served/le9959.pdf>
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| 414.578 (Community Health Improvement Plan) | Section 2: 2. The authority shall:1. Require a coordinated care organization, in accordance with ORS 414.152 (Duty of state agencies to work with local health departments) and 414.153 (Services provided by local public health authorities), to spend no less than three percent of its global budget on investments:
	1. In local public health administered programs or services that improve health equity by addressing the preventable differences in the burden of disease, injury or violence or in opportunities to achieve optimal health that are experienced by socially disadvantaged populations;
	2. In community-based programs addressing the social determinants of health;
	3. In efforts to diversify care locations;
	4. In programs or services that improve the overall health of the community;
	5. In programs that support the coordinated care organization in achieving performance and quality metrics…”
 | LPHAs provide direct and population-level services that keep people healthy throughout their lives and reduce the overall cost of health care. However, **there are no requirements that CCOs fund or support these existing programs. This risks duplication and fragmentation of services.** |
| **Align funding cycles:** Have legislation state that County agreements with CCOs must be revisited annually/biannually and define that timeframe. Currently, funding cycle timelines are inconsistent from CCO to CCO and inconsistent with County budget cycles. This results in administrative burden being passed down to CCO partners.  | 414.152 (Duty of state agencies to work with local health departments) | Add language about how agreements must be revisited annually/biannually. | Allows for flexibility and adaptiveness in these agreements to better serve communities.  |
| 414.153 (Services provided by local health departments) | Add language that the state will align funding cycle timeframes across the system/CCOs to improve system coordination | Aligned funding cycles allow CCOs and their partners to coordinate effectively and avoid duplication of work. |
| **Align local planning requirements and metrics held by the CCOs, LPHAs, and CMHPs, including the CHIP:** All are part of the public health system, yet we all have disparate plans with inconsistent data. Aligning local planning requirements and metrics would reduce the administrative burden for all partners. Aligning local planning could also support better coordinated – and more strategically funded – initiatives. | 414.211 (Medicaid Advisory Committee) | Add following members: * Public health/population health expert
* Climate and health expert
* Housing provider professional
* Nutrition expert (could specify WIC or SNAP – someone with experience navigating nutrition support systems)
 | MAC advises OHA on administration of the state Medicaid program (including the 1115 Waiver, HRSNs, and SHARE investments). Adding seats for these additional experts will encourage system alignment and effective implementation of new initiatives. |
| 414.572 (Coordinated Care Organizations) | Explicitly name county health/social service providers (LPHAs, CMHPs, APD, Housing, etc.) from each jurisdiction served by the CCO as organizations that must be represented “when possible” on the CCO governing bodies. | This encourages alignment across the region served by the CCO and across all parts of the health/social care system (especially important as CCOs roll out HRSNs). |
| 414.575 (Community Advisory Council) | Explicitly name the LPHA in each jurisdiction served by the CCO as organizations that must be represented “when possible” on the CCO CACs. | The CACs oversee the Community Health Improvement Plan – since the LPHA is the entity that also oversees (for Public Health Accreditation and eventually for Public Health Modernization), an LPHA representative will encourage alignment between these two plans (and/or facilitate a shared CHIP).  |
| 414.577 (Community health assessment and adoption of community health improvement plan rules) | 1. “The health improvement plan must include aligned and coordinated strategies for achieving shared local priorities.” | Having shared priorities is essential, but orgs also need to align their strategies so they aren’t duplicating/working against each other.  |
| 414.578 (Community Health Improvement Plan) |  | This one seems solid to me, but MCH and other child/adolescent folks should look at the language below and let me know if there are areas to strengthen.  |
| 414.638 (Metrics and Scoring Committee) | 1. “The members of the subcommittee serve two-year terms and must include:
	1. Three members at large;
	2. Three individuals with expertise in health outcomes measures, Including one member of the Public Health Advisory Board with expertise in public health and/or population health data; and
	3. Three representatives of coordinated care organizations.
 | This would encourage alignment of metrics across the health system. |

## [ORS 414.025](https://oregon.public.law/statutes/ors_414.025)

(Definitions)

## [ORS 414.150](https://oregon.public.law/statutes/ors_414.150)

Purpose of ORS 414.150-414.153

It is the purpose of ORS 414.150 (Purpose of ORS 414.150 to 414.153) to 414.153 (Services provided by local health departments) to take advantage of opportunities to:

1. Enhance the state and local public health partnership;
2. Improve the access to care and health status of women and children; and
3. Strengthen public health programs and services at the local level. [1991 c.337 §1; 2015 c.736 §58]

## [ORS 414.152](https://oregon.public.law/statutes/ors_414.152)

Duty of state agencies to work with local health departments

To capitalize on the successful public health programs provided by local health departments and the sizable investment by state and local governments in the public health system, state agencies shall encourage agreements that allow local health departments and other publicly supported programs to continue to be the providers of those prevention and health promotion services now available, plus other maternal and child health services such as prenatal outreach and care, child health services and family planning services to women and children who become eligible for poverty level medical assistance program benefits pursuant to ORS 414.153 (Services provided by local health departments). [1991 c.337 §3; 2015 c.736 §59]

## [ORS 414.153](https://oregon.public.law/statutes/ors_414.153)

Services provided by local health departments

In order to make advantageous use of the system of public health care and services available through local health departments and other publicly supported programs and to ensure access to public health care and services through contract under ORS chapter 414, the state shall:

1. Unless cause can be shown why such an agreement is not feasible, require and approve agreements between coordinated care organizations and publicly funded providers for reasonable and sufficient for services in the following categories:
	1. Immunizations;
	2. Sexually transmitted infections; and
	3. Other communicable diseases;
2. Allow members of coordinated care organizations to receive from fee-for-service providers:
	1. Family planning services;
	2. Human immunodeficiency virus and acquired immune deficiency syndrome prevention services; and
	3. Maternity case management if the Oregon Health Authority determines that a coordinated care organization cannot adequately provide the services;
3. Encourage and approve agreements between coordinated care organizations and publicly funded providers for reasonable and sufficient payment for services in the following categories:
	1. Maternity case management;
	2. Well-child care;
	3. Prenatal care;
	4. School-based clinics;
	5. Health care and services for children provided through schools and Head Start programs; and
	6. Screening services to provide early detection of health care problems among low income women and children, migrant workers and other special population groups; and
4. Recognize the responsibility of counties under ORS 430.620 (Establishment of community mental health and developmental disabilities programs by one or more counties) to operate community mental health programs by requiring a written agreement between each coordinated care organization and the local mental health authority in the area served by the coordinated care organization, unless cause can be shown why such an agreement is not feasible under criteria established by the Oregon Health Authority. The written agreements:
	1. May not prevent coordinated care organizations from contracting with other public or private providers for mental health or chemical dependency services;
	2. Must include agreed upon outcomes; and
	3. Must describe the authorization and payments necessary to maintain the mental health safety net system and to maintain the efficient and effective management of the following responsibilities of local mental health authorities, with respect to the service needs of members of the coordinated care organization:
		1. Management of children and adults at risk of entering or who are transitioning from the Oregon State Hospital or from residential care;
		2. Care coordination of residential services and supports for adults and children;
		3. Management of the mental health crisis system;
		4. Management of community-based specialized services, including but not limited to supported employment and education, early psychosis programs, assertive community treatment or other types of intensive case management programs and home-based services for children; and
		5. Management of specialized services to reduce recidivism of individuals with mental illness in the criminal justice system. [1991 c.337 §4; 1993 c.592 §1; 2009 c.595 §286; 2011 c.602 §24; 2015 c.27 §42; 2015 c.736 §60; 2015 c.798 §4; 2019 c.280 §8]

## [ORS 414.211](https://oregon.public.law/statutes/ors_414.211)

Medicaid Advisory Committee

1. There is established a Medicaid Advisory Committee consisting of not more than 15 members appointed by the Governor.
2. The committee shall be composed of:
	1. A physician licensed under ORS chapter 677;
	2. Two members of health care consumer groups that include Medicaid recipients;
	3. Two Medicaid recipients, one of whom shall be a person with a disability;
	4. The Director of the Oregon Health Authority or designee;
	5. The Director of Human Services or designee;
	6. Health care providers;
	7. Persons associated with health care organizations, including but not limited to coordinated care organizations under contract to the Medicaid program; and
	8. Members of the general public.
3. In making appointments, the Governor shall consult with appropriate professional and other interested organizations. All members appointed to the committee shall be familiar with the medical needs of low income persons.
4. The term of office for each member shall be two years, but each member shall serve at the pleasure of the Governor.
5. Members of the committee shall receive no compensation for their services but, subject to any applicable state law, shall be allowed actual and necessary travel expenses incurred in the performance of their duties from the Oregon Health Authority Fund. [1995 c.727 §43; 2007 c.70 §192; 2009 c.595 §287; 2011 c.602 §37; 2011 c.720 §132]

## [ORS 414.572](https://oregon.public.law/statutes/ors_414.572)

Coordinated Care Organizations

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:
	1. Have demonstrated experience and a capacity for managing financial risk and establishing financial reserves
	2. Meet the following minimum financial requirements:
		1. 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.
		2. 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 (Capital and surplus requirements) (6), 732.225 (Impairment of required capitalization prohibited), 732.230 (Order to cure impairment) and 750.045 (Required capitalization).
		3. 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).
	3. Operate within a fixed global budget and, by January 1, 2023, spend on primary care, as defined in section 2, chapter 575, Oregon Laws 2015, 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.
	4. Develop and implement alternative payment methodologies that are based on health care quality and improved health outcomes.
	5. Coordinate the delivery of physical health care, behavioral health care, oral health care and covered long-term care services.
	6. 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:
	1. Each member of the coordinated care organization receives integrated person centered care and services designed to provide choice, independence and dignity.
	2. Each member has a consistent and stable relationship with a care team that is responsible for comprehensive care management and service delivery.
	3. 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.
	4. Members receive comprehensive transitional care, including appropriate follow-up, when entering and leaving an acute care facility or a long term care setting.
	5. Members are provided:
		1. Assistance in navigating the health care delivery system;
		2. Assistance in accessing community and social support services and statewide resources;
		3. 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
		4. 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 (Definitions for ORS 413.550 to 413.559).
	6. 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.
	7. 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.
	8. Each coordinated care organization complies with the safeguards for members described in ORS 414.605 (Consumer and provider protections).
	9. Each coordinated care organization convenes a community advisory council that meets the criteria specified in ORS 414.575 (Community advisory councils).
	10. 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 (Behavioral health treatment), to reduce the use of avoidable emergency room visits and hospital admissions.
	11. Members have a choice of providers within the coordinated care organization’s network and that providers participating in a coordinated care organization:
		1. Work together to develop best practices for care and service delivery to reduce waste and improve the health and well-being of members.
		2. 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.
		3. Emphasize prevention, healthy lifestyle choices, evidence-based practices, shared decision-making and communication.
		4. Are permitted to participate in the networks of multiple coordinated care organizations.
		5. Include providers of specialty care.
		6. 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.
		7. 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.
	12. Each coordinated care organization reports on outcome and quality measures adopted under ORS 414.638 (Metrics and scoring subcommittee) and participates in the health care data reporting system established in ORS 442.372 (Definitions for ORS 442.372 and 442.373) and 442.373 (Health care data reporting by health insurers).
	13. Each coordinated care organization uses best practices in the management of finances, contracts, claims processing, payment functions and provider networks.
	14. Each coordinated care organization participates in the learning collaborative described in ORS 413.259 (Patient centered primary care home program and behavioral health home program) (3).
	15. Each coordinated care organization has a governing body that complies with ORS 414.584 (Meetings of coordinated care organization governing body to be open to public) and that includes:
		1. At least one member representing persons that share in the financial risk of the organization;
		2. A representative of a dental care organization selected by the coordinated care organization;
		3. The major components of the health care delivery system;
		4. At least two health care providers in active practice, including:
			1. A physician licensed under ORS chapter 677 or a nurse practitioner licensed under ORS 678.375 (Nurse practitioners), whose area of practice is primary care; and
			2. A behavioral health provider;
		5. 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
		6. 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.
		7. 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.
		8. 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.
		9. Each coordinated care organization works with the Tribal Advisory Council established in ORS 414.581 (Tribal Advisory Council established) and has a dedicated tribal liaison, selected by the council, to:
			1. 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;
			2. Participate in the community health assessment and the development of the health improvement plan;
			3. Communicate regularly with the Tribal Advisory Council; and
			4. Be available for training by the office within the authority that is responsible for tribal affairs, any federally recognized tribe in Oregon and the urban Indian health program that is located within the area served by the coordinated care organization and operated by an urban Indian organization pursuant to 25 U.S.C. 1651.
3. The authority shall consider the participation of area agencies and other nonprofit agencies in the configuration of coordinated care organizations.
4. In selecting one or more coordinated care organizations to serve a geographic area, the authority shall:
	1. For members and potential members, optimize access to care and choice of providers;
	2. For providers, optimize choice in contracting with coordinated care organizations; and
	3. 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. [Formerly 414.625; 2021 c.453 §13]

## [ORS 414.575](https://oregon.public.law/statutes/ors_414.575)

Community advisory councils

1. A coordinated care organization must have a community advisory council to ensure that the health care needs of the consumers and the community are being addressed. The council must:
	1. Include representatives of the community and of each county government served by the coordinated care organization, but consumer representatives must constitute a majority of the membership; and
	2. Have its membership selected by a committee composed of equal numbers of county representatives from each county served by the coordinated care organization and members of the governing body of the coordinated care organization.
2. The duties of the council include, but are not limited to:
	1. Identifying and advocating for preventive care practices to be utilized by the coordinated care organization;
	2. Overseeing a community health assessment and adopting a community health improvement plan in accordance with ORS 414.577 (Community health assessment and adoption of community health improvement plan); and
	3. Annually publishing a report on the progress of the community health improvement plan.
3. The community health improvement plan adopted by the council should describe the scope of the activities, services and responsibilities that the coordinated care organization will consider upon implementation of the plan. The activities, services and responsibilities defined in the plan shall include a plan and a strategy for integrating physical, behavioral and oral health care services and may include, but are not limited to:
	1. Analysis and development of public and private resources, capacities and metrics based on ongoing community health assessment activities and population health priorities;
	2. Health policy;
	3. System design;
	4. Outcome and quality improvement;
	5. Integration of service delivery; and
	6. Workforce development.
4. The council shall meet at least once every three months. The council shall post a report of its meetings and discussions to the website of the coordinated care organization and other websites appropriate to keeping the community informed of the council’s activities. The council, the governing body of the coordinated care organization or a designee of the council or governing body has discretion as to whether public comments received at meetings that are open to the public will be included in the reports posted to the website and, if so, which comments are appropriate for posting.
5. If the regular council meetings are not open to the public and do not provide an opportunity for members of the public to provide written and oral comments, the council shall hold quarterly meetings:
	1. That are open to the public and attended by the members of the council;
	2. At which the council shall report on the activities of the coordinated care organization and the council;
	3. At which the council shall provide written reports on the activities of the coordinated care organization; and
	4. At which the council shall provide the opportunity for the public to provide written or oral comments.
	5. The coordinated care organization shall post to the organization’s website contact information for, at a minimum, the chairperson, a member of the community advisory council or a designated staff member of the organization.
6. Meetings of the council are not subject to ORS 192.610 (Definitions for ORS 192.610 to 192.690) to 192.690 (Exceptions to ORS 192.610 to 192.690). [Formerly 414.627]

## [ORS 414.577](https://oregon.public.law/statutes/ors_414.577)

Community health assessment and adoption of community health improvement plan rules

1. A coordinated care organization shall collaborate with local public health authorities and hospitals located in areas served by the coordinated care organization to conduct a community health assessment and adopt a community health improvement plan, shared with and endorsed by the coordinated care organization, local public health authorities and hospitals, to serve as a strategic population health and health care services plan for the residents of the areas served by the coordinated care organization, local public health authorities and hospitals. The health improvement plan must include 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 and hospitals. [2019 c.529 §1]

## [ORS 414.578](https://oregon.public.law/statutes/ors_414.578)

Community health improvement plan

1. A community health improvement plan adopted by a coordinated care organization and its community advisory council in accordance with ORS 414.577 (Community health assessment and adoption of community health improvement plan) 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:
	1. 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
	2. 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:
	1. 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;
	2. 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;
	3. 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;
	4. Improve the integration of all services provided to meet the needs of children, adolescents and families;
	5. Focus on primary care, behavioral health and oral health; and
	6. 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:
4. Programs developed by the Early Learning Council and Early Learning Hubs;
5. Programs developed by the Youth Development Council in the region;
6. The Healthy Start Family Support Services program in the region;
7. The Cover All People program and other medical assistance programs;
8. Relief nurseries in the region;
9. Community health centers;
10. Oral health care providers;
11. Community mental health providers;
12. Administrators of county health department programs that offer preventive health services to children;
13. Hospitals in the region; and
14. Other appropriate child and adolescent health program administrators.
15. 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.
16. 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. [Formerly 414.629; 2021 c.554 §5]

Note: The amendments to section 2, chapter 467, Oregon Laws 2021, by section 3, chapter 467, Oregon Laws 2021, become operative upon receipt of approval from the Centers for Medicare and Medicaid Services to carry out section 2, chapter 467, Oregon Laws 2021. See section 4, chapter 467, Oregon Laws 2021. The text that is operative on and after the approval is set forth for the user’s convenience.

Sec. 2. (1) As used in this section, “health equity” has the meaning prescribed by the Oregon Health Policy Board and adopted by the Oregon Health Authority by rule.

1. The authority shall:
	1. Require a coordinated care organization to spend no less than three percent of its global budget on investments:
		1. In local public health administered programs or services that improve health equity by addressing the preventable differences in the burden of disease, injury or violence or in opportunities to achieve optimal health that are experienced by socially disadvantaged populations;
		2. In community-based programs addressing the social determinants of health;
		3. In efforts to diversify care locations; or
		4. In programs or services that improve the overall health of the community; or
	2. That enhance payments to:
		1. Providers who address the need for culturally and linguistically appropriate services in their communities;
		2. Providers who can demonstrate that increased funding will improve health services provided to the community as a whole; or
		3. Support staff based in the community that aid all underserved populations, including but not limited to peer-to-peer support staff with cultural backgrounds, health system navigators in nonmedical settings and public guardians.
	3. Require a coordinated care organization to spend at least 30 percent of the funds described in paragraph (a) of this subsection on programs or efforts to achieve health equity for racial, cultural or traditionally underserved populations in the communities served by the coordinated care organization.
	4. Require a coordinated care organization to spend at least 20 percent of the funds described in paragraph (a) of this subsection on efforts to:
		1. Improve the behavioral health of members;
		2. Improve the behavioral health care delivery system in the community served by the coordinated care organization;
		3. Create a culturally and linguistically competent health care workforce; or
		4. Improve the behavioral health of the community as a whole.
2. Expenditures described in subsection (2) of this section are in addition to the expenditures required by ORS 414.572 (1)(b)(C) and must:
	1. Be part of a plan developed in collaboration with or directed by members of organizations or organizations that serve local priority populations that are underserved in communities served by the coordinated care organization, including but not limited to regional health equity coalitions, and be approved by the coordinated care organization’s community advisory council;
	2. Demonstrate, through practice-based or community-based evidence, improved health outcomes for individual members of the coordinated care organization or the overall community served by the coordinated care organization;
	3. Be expended from a coordinated care organization’s global budget with the least amount of state funding; and
	4. Be counted as medical expenses by the authority in a coordinated care organization’s base medical budget when calculating the coordinated care organization’s global budget and flexible spending requirements for a given year.
3. Expenditures by a coordinated care organization in working with one or more of the nine federally recognized tribes in this state or urban Indian health programs to achieve health equity may qualify as expenditures under subsection (2) of this section.
4. The authority shall:
	1. Make publicly available the outcomes described in subsection (3)(b) of this section; and
	2. Report expenditures under subsection (2) of this section to the Centers for Medicare and Medicaid Services.
5. The authority shall convene an oversight committee in consultation with the office within the authority that is charged with ensuring equity and inclusion. The oversight committee shall be composed of members who represent the regional and demographic diversity of this state based on statistical evidence compiled by the authority about medical assistance recipients and at least one representative from the nine federally recognized tribes in this state or urban Indian health programs. The oversight committee shall:
	1. Evaluate the impact of expenditures described in subsection (2) of this section on promoting health equity and improving the social determinants of health in the communities served by each coordinated care organization;
	2. Recommend best practices and criteria for investments described in subsection (2) of this section; and
	3. Resolve any disputes between the authority and a coordinated care organization over what qualifies as an expenditure under subsection (2) of this section.

## [ORS 414.638](https://oregon.public.law/statutes/ors_414.638)

[Metrics and Scoring Subcommittee](https://www.oregon.gov/oha/HPA/ANALYTICS/Quality%20Metrics%20Committee%20Docs/Aligned-Measures-Menu.pdf)

1. 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:
	1. Three members at large;
	2. Three individuals with expertise in health outcomes measures; and
	3. Three representatives of coordinated care organizations.
2. The subcommittee shall select, from the health outcome and quality measures identified by the Health Plan Quality Metrics Committee, the health outcome and quality measures applicable to services provided by coordinated care organizations. 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.
3. The subcommittee shall evaluate the health outcome and quality measures annually, reporting recommendations based on its findings to the Health Plan Quality Metrics Committee, and adjust the measures to reflect:
	1. The amount of the global budget for a coordinated care organization;
	2. Changes in membership of the organization;
	3. The organization’s costs for implementing outcome and quality measures; and
	4. The community health assessment and the costs of the community health assessment conducted by the organization under ORS 414.575 (Community advisory councils).
4. The authority 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. [2011 c.602 §10; 2012 c.8 §21; 2015 c.389 §10]

## [ORS 414.719](https://oregon.public.law/statutes/ors_414.719)

Housing navigation services and social determinants of health

The Oregon Health Authority shall adopt by rule requirements for coordinated care organizations to provide housing navigation services and address the social determinants of health through care coordination. [2021 c.667 §11]