

House Bill 4115

Sponsored by Representative SALINAS, Senator MANNING JR, Representative ALONSO LEON, Senators FREDERICK, WAGNER; Representatives DOHERTY, HERNANDEZ, HOLVEY, MEEK, MITCHELL, NERON, NOSSE, PRUSAK, SANCHEZ, SCHOUTEN, Senators DEMBROW, KNOPP, MONNES ANDERSON (Presession filed.)

SUMMARY

The following summary is not prepared by the sponsors of the measure and is not a part of the body thereof subject to consideration by the Legislative Assembly. It is an editor's brief statement of the essential features of the measure **as introduced**.

Requires health care providers, including coordinated care organizations, and companies providing health care interpreters to health care providers to use health care interpreters who are qualified or certified by Oregon Health Authority. Specifies exceptions. Requires authority to cooperate with Oregon Council on Health Care Interpreters to establish registry of qualified and certified health care interpreters.

Requires authority, by September 15, 2020, to make recommendations to interim committee of House of Representatives related to health on design of health care interpreter program meeting specified criteria.

Requires companies providing health care interpreters to register with authority and meet certain requirements.

Makes health care interpreters subject workers for purposes of workers' compensation benefits. Declares emergency, effective on passage.

A BILL FOR AN ACT

1
2 Relating to health care interpreters; creating new provisions; amending ORS 192.630, 413.550,
3 413.552, 413.556, 413.558, 414.572, 656.027 and 657.046; and declaring an emergency.

4 Whereas current law contains a loophole for health care providers and interpretation service
5 companies to justify using untrained health care interpreters despite the availability of health care
6 interpreters who are qualified or certified by the Oregon Health Authority; and

7 Whereas current law does not hold accountable health care providers and interpretation service
8 companies for failing to use qualified or certified interpreters or for failing to use best practices in
9 providing health care interpretation services; and

10 Whereas there is currently no complaint process for health care interpreters who experience
11 wage or other labor violations; and

12 Whereas there is evidence that 20 percent of the health care interpreters who are being actively
13 recruited by interpretation service companies are not qualified or certified by the authority, which
14 drives down wages for interpreters and increases the companies' profits; and

15 Whereas there is a growing demand for health care interpreters in rural communities in this
16 state, especially for interpreters capable of interpreting languages of limited diffusion in those areas;
17 and

18 Whereas health care interpreters suffer from the inequitable business practices of interpretation
19 service companies, coordinated care organizations and other health care providers; and

20 Whereas due to the low demand for their services, the low wages and reimbursement and the
21 rising cost of training and testing, current and potential health care interpreters are reluctant to
22 invest in training, testing, qualification or certification because of the low return on their invest-
23 ment; and

24 Whereas there is a lack of uniformity statewide in the quality of health care interpretation

NOTE: Matter in **boldfaced** type in an amended section is new; matter *[italic and bracketed]* is existing law to be omitted. New sections are in **boldfaced** type.

1 services; now, therefore,

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

3 **SECTION 1. Sections 2 to 4 of this 2020 Act are added to and made a part of ORS 413.550**
4 **to 413.558.**

5 **SECTION 2. (1) Except as provided in subsection (3) of this section, a health care pro-**
6 **vider who is not a certified health care interpreter or a qualified health care interpreter shall**
7 **use a health care interpreter from the health care interpreter registry to communicate with**
8 **a patient with limited English proficiency or a patient who communicates in sign language,**
9 **when providing health care to the patient.**

10 **(2) Except as provided in subsection (3) of this section, an interpretation service company**
11 **may not employ or contract with health care interpreters who are not qualified health care**
12 **interpreters, certified health care interpreters or health care interpreters who are enrolled**
13 **in a health care interpreter training program approved by the Oregon Council on Health Care**
14 **Interpreters.**

15 **(3) A health care provider may use a health care interpreter that is not listed on the**
16 **health care interpreter registry only if the provider verifies, in the manner prescribed by the**
17 **Oregon Health Authority by rule, that the provider has taken all steps necessary to obtain**
18 **a qualified or certified health care interpreter in accordance with ORS 413.558 and rules**
19 **adopted by the authority.**

20 **SECTION 3. (1) With the advice of the Oregon Council on Health Care Interpreters, the**
21 **Oregon Health Authority shall implement by rule policies and processes to hold accountable:**

22 **(a) Interpretation service companies and health care providers for using only qualified**
23 **or certified health care interpreters; and**

24 **(b) Health care interpreters and health care interpreter training programs for the quality**
25 **of interpretation services provided.**

26 **(2) The policies and procedures must include, at a minimum:**

27 **(a) Investigating and resolving complaints about:**

28 **(A) The failure of interpretation service companies and health care providers to use**
29 **qualified or certified health care interpreters;**

30 **(B) Interpretation service companies in regard to unfair labor or contracting practices,**
31 **discrimination, violation of consumer protections, risks to the health or safety of patients,**
32 **conflicts of interest or compliance with law; and**

33 **(C) Health care interpreters in regard to discrimination, risks to the health or safety of**
34 **patients, conflicts of interest or scope of practice.**

35 **(b) No later than January 1, 2022, collaborating with the Bureau of Labor and Industries**
36 **or the Department of Justice, as appropriate, to investigate complaints filed under this sec-**
37 **tion and impose appropriate remedial measures or civil penalties in accordance with ORS**
38 **183.745. Health care interpreters may be subject to suspension or revocation of their quali-**
39 **fication or certification but not to civil penalties.**

40 **(c) Tracking state expenditures on providing health care interpretation services and the**
41 **portion of the expenditures that are spent on administrative costs.**

42 **SECTION 4. (1) A person may not operate an interpretation service company in this state**
43 **unless the company is registered with the Oregon Health Authority.**

44 **(2) A person shall apply to register a company by submitting an application and paying**
45 **a fee to the authority. The authority shall register the company if the company meets cri-**

1 **teria established by the authority by rule.**

2 **(3) A registered interpretation service company shall:**

3 **(a) Notify a health care provider if a health care interpreter provided by the company is**
 4 **not listed on the health care interpreter registry or currently enrolled in a training program**
 5 **approved by the Oregon Council on Health Care Interpreters;**

6 **(b) Report to the authority, in the form and manner specified by the authority, every**
 7 **case in which the company provides health care interpretation services to a patient using a**
 8 **health care interpreter who is not listed on the health care interpreter registry; and**

9 **(c) Provide, upon the request of a health care interpreter, the terms of the contract be-**
 10 **tween the company and the health care interpreters that the company provides.**

11 **SECTION 5. (1) As used in this section:**

12 **(a) “Health care interpreter registry” has the meaning given that term in ORS 413.550.**

13 **(b) “Health care provider” has the meaning given that term in ORS 413.550.**

14 **(c) “Interpretation service company” has the meaning given that term in ORS 413.550.**

15 **(d) “Qualified or certified health care interpreters” means qualified health care inter-**
 16 **preters or certified health care interpreters as defined in ORS 413.550.**

17 **(2) The Oregon Health Authority shall design a program to:**

18 **(a) Provide all health care interpreter training in this state to professionalize the health**
 19 **care interpreter workforce and ensure the use of qualified or certified health care inter-**
 20 **preters throughout this state. The training must be free or provided at a cost that is af-**
 21 **fordable.**

22 **(b) Conduct the testing, qualification and certification of health care interpreters.**

23 **(c) Ensure that all health care providers and interpretation service companies use health**
 24 **care interpreters from the health care interpreter registry.**

25 **(d) Provide a website or otherwise implement a system, in collaboration with a labor**
 26 **union or other representative of the health care interpreter workforce, that allows a patient**
 27 **or health care provider to access the health care interpreter registry and schedule appoint-**
 28 **ments with qualified or certified health care interpreters.**

29 **(3) No later than September 15, 2020, the authority shall report to the interim committee**
 30 **of the House of Representatives related to health on the program design, costs to implement**
 31 **the program and any legislative changes needed to implement the program.**

32 **SECTION 6. ORS 413.550 is amended to read:**

33 **413.550. As used in ORS 413.550 to 413.558:**

34 **(1) “Certified health care interpreter” means an individual who has been approved and certified**
 35 **by the Oregon Health Authority.**

36 **(2) “Coordinated care organization” has the meaning given that term in ORS 414.025.**

37 **[(2)] (3) “Health care” means medical, surgical or hospital care or any other remedial care re-**
 38 **cognized by state law, including physical and behavioral health care.**

39 **[(3)] (4) “Health care interpreter” means an individual who is readily able to:**

40 **(a) Communicate with a person with limited English proficiency;**

41 **(b) Accurately interpret the oral statements of a person with limited English proficiency, or the**
 42 **statements of a person who communicates in sign language, into English;**

43 **(c) Sight translate documents from a person with limited English proficiency;**

44 **(d) Interpret the oral statements of other persons into the language of the person with limited**
 45 **English proficiency or into sign language; and**

1 (e) Sight translate documents in English into the language of the person with limited English
2 proficiency.

3 (5) **“Health care interpreter registry” means the registry described in ORS 413.556 that**
4 **is administered by the authority.**

5 (6) **“Health care provider” means an individual, coordinated care organization or other**
6 **entity licensed or certified to provide health care in this state that is reimbursed with public**
7 **funds, in whole or in part.**

8 (7) **“Interpretation service company” means an entity engaged in the business of con-**
9 **tracting with health care providers to provide health care interpreters.**

10 [(4)] (8) “Person with limited English proficiency” means a person who, by reason of place of
11 birth or culture, speaks a language other than English and does not speak English with adequate
12 ability to communicate effectively with a health care provider.

13 [(5)] (9) “Qualified health care interpreter” means an individual who has received a valid letter
14 of qualification from the authority.

15 [(6)] (10) “Sight translate” means to translate a written document into spoken or sign language.

16 **SECTION 7.** ORS 413.552 is amended to read:

17 413.552. (1) The Legislative Assembly finds that persons with limited English proficiency, or who
18 communicate in sign language, are often unable to interact effectively with health care providers.
19 Because of language differences, persons with limited English proficiency, or who communicate in
20 sign language, are often excluded from health care services, experience delays or denials of health
21 care services or receive health care services based on inaccurate or incomplete information.

22 (2) The Legislative Assembly further finds that the lack of competent health care interpreters
23 among health care providers impedes the free flow of communication between the health care pro-
24 vider and patient, preventing clear and accurate communication and the development of empathy,
25 confidence and mutual trust that is essential for an effective relationship between health care pro-
26 vider and patient.

27 (3) It is the policy of the Legislative Assembly to require the use of certified health care inter-
28 preters or qualified health care interpreters [*whenever possible*] **to the greatest extent practicable**
29 **to ensure the accurate and adequate provision of health care to persons with limited English profi-**
30 **ciency and to persons who communicate in sign language.**

31 (4) It is the policy of the Legislative Assembly that health care for persons with limited English
32 proficiency be provided according to the guidelines established under the policy statement issued
33 August 30, 2000, by the U.S. Department of Health and Human Services, Office for Civil Rights,
34 entitled, “Title VI of the Civil Rights Act of 1964; Policy Guidance on the Prohibition Against Na-
35 tional Origin Discrimination As It Affects Persons With Limited English Proficiency,” and the 1978
36 Patient’s Bill of Rights.

37 **SECTION 8.** ORS 413.556 is amended to read:

38 413.556. The Oregon Council on Health Care Interpreters shall work in cooperation with the
39 Oregon Health Authority to:

40 (1) Develop testing, qualification and certification standards for health care interpreters for
41 persons with limited English proficiency and for persons who communicate in sign language.

42 (2) Coordinate with other states, the federal government or professional organizations to develop
43 and implement educational and testing programs for health care interpreters.

44 (3) [*Examine operational and funding issues, including but not limited to the feasibility of devel-*
45 *oping*] **Establish a central registry for all health care interpreters who are qualified or certified**

1 **by the authority, to be maintained by the authority, and an** annual subscription mechanism for
 2 **[health care interpreters] the registry.**

3 (4) Do all other acts as shall be necessary or appropriate under the provisions of ORS 413.550
 4 to 413.558.

5 **SECTION 9.** ORS 413.558 is amended to read:

6 413.558. (1) In consultation with the Oregon Council on Health Care Interpreters, the Oregon
 7 Health Authority shall by rule establish procedures for testing, qualification and certification of
 8 health care interpreters for persons with limited English proficiency or for persons who communi-
 9 cate in sign language, including but not limited to:

10 (a) Minimum standards for qualification and certification as a health care interpreter, **which**
 11 **may be modified as necessary**, including:

12 (A) Oral and written language skills in English and in the language for which health care in-
 13 terpreter qualification or certification is granted; *[and]*

14 (B) Formal education or training in medical terminology, anatomy and physiology, medical in-
 15 terpreting ethics and interpreting skills; **and**

16 (C) **A code of ethics based, at a minimum, on accepted national or international stan-**
 17 **dards;**

18 (b) Categories of expertise of health care interpreters based on the English and non-English
 19 skills, or interpreting skills, and the medical terminology skills of the person seeking qualification
 20 or certification;

21 (c) Procedures for receiving applications and for examining applicants for qualification or cer-
 22 tification;

23 (d) The content and administration of required examinations;

24 (e) The requirements and procedures for reciprocity of qualification and certification for health
 25 care interpreters qualified or certified in another state or territory of the United States or by an-
 26 other certifying body in the United States; and

27 (f) Fees for application, examination, initial issuance, renewal and reciprocal acceptance of
 28 qualification or certification as a health care interpreter if deemed necessary by the authority.

29 (2) Any person seeking qualification or certification as a health care interpreter must submit
 30 an application to the authority. If the applicant meets the requirements for qualification or certi-
 31 fication established by the authority under this section, the authority shall issue a letter of quali-
 32 fication or a certification to the health care interpreter. **The authority shall make a**
 33 **determination on an application no later than 60 days after the date the application is re-**
 34 **ceived by the authority.**

35 (3) The authority shall work with other states, the federal government or professional organ-
 36 izations to develop educational and testing programs and procedures for the qualification and cer-
 37 tification of health care interpreters.

38 (4) In addition to the requirements for qualification established under subsection (1) of this
 39 section, a person may be qualified as a health care interpreter only if the person:

40 (a) Is able to fluently interpret the dialect, slang or specialized vocabulary of the non-English
 41 language for which qualification is sought; and

42 (b) Has had at least 60 hours of health care interpreter training that includes anatomy and
 43 physiology and concepts of medical interpretation.

44 (5) A person may not use the title of “qualified health care interpreter” in this state unless the
 45 person has met the requirements for qualification established under subsections (1) and (4) of this

1 section and has been issued a valid letter of qualification by the authority.

2 (6) In addition to the requirements for certification established under subsection (1) of this sec-
 3 tion, a person may be certified as a health care interpreter only if:

4 (a) The person has met all the requirements established under subsection (4) of this section; and

5 (b) The person has passed written and oral examinations required by the authority in English,
 6 in a non-English language or sign language and in medical terminology.

7 (7) A person may not use the title of “certified health care interpreter” in this state unless the
 8 person has met the requirements for certification established under subsections (1) and (6) of this
 9 section and has been issued a valid certification by the authority.

10 **(8) In consultation with the council, the authority shall adopt by rule the steps that must**
 11 **be taken by a health care provider and the verification required to allow the use of a health**
 12 **care interpreter who is not listed on the health care interpreter registry established under**
 13 **ORS 413.556, in accordance with section 2 of this 2020 Act.**

14 **(9) The council shall adopt procedures to evaluate the quality of health care interpreta-**
 15 **tion services provided by or used by interpretation service companies, health care providers**
 16 **and health care interpreters listed on the health care interpreter registry.**

17 **SECTION 10.** ORS 192.630 is amended to read:

18 192.630. (1) All meetings of the governing body of a public body shall be open to the public and
 19 all persons shall be permitted to attend any meeting except as otherwise provided by ORS 192.610
 20 to 192.690.

21 (2) A quorum of a governing body may not meet in private for the purpose of deciding on or
 22 deliberating toward a decision on any matter except as otherwise provided by ORS 192.610 to
 23 192.690.

24 (3) A governing body may not hold a meeting at any place where discrimination on the basis
 25 of race, color, creed, sex, sexual orientation, national origin, age or disability is practiced. However,
 26 the fact that organizations with restricted membership hold meetings at the place does not restrict
 27 its use by a public body if use of the place by a restricted membership organization is not the pri-
 28 mary purpose of the place or its predominant use.

29 (4)(a) Meetings of the governing body of a public body shall be held:

30 (A) Within the geographic boundaries over which the public body has jurisdiction;

31 (B) At the administrative headquarters of the public body;

32 (C) At the nearest practical location; or

33 (D) If the public body is a state, county, city or special district entity, within Indian country of
 34 a federally recognized Oregon Indian tribe that is within the geographic boundaries of this state.
 35 For purposes of this subparagraph, “Indian country” has the meaning given that term in 18 U.S.C.
 36 1151.

37 (b) Training sessions may be held outside the jurisdiction as long as no deliberations toward a
 38 decision are involved.

39 (c) A joint meeting of two or more governing bodies or of one or more governing bodies and the
 40 elected officials of one or more federally recognized Oregon Indian tribes shall be held within the
 41 geographic boundaries over which one of the participating public bodies or one of the Oregon Indian
 42 tribes has jurisdiction or at the nearest practical location.

43 (d) Meetings may be held in locations other than those described in this subsection in the event
 44 of an actual emergency necessitating immediate action.

45 (5)(a) It is discrimination on the basis of disability for a governing body of a public body to meet

1 in a place inaccessible to persons with disabilities, or, upon request of a person who is deaf or hard
 2 of hearing, to fail to make a good faith effort to have an interpreter for persons who are deaf or
 3 hard of hearing provided at a regularly scheduled meeting. The sole remedy for discrimination on
 4 the basis of disability shall be as provided in ORS 192.680.

5 (b) The person requesting the interpreter shall give the governing body at least 48 hours' notice
 6 of the request for an interpreter, shall provide the name of the requester, sign language preference
 7 and any other relevant information the governing body may request.

8 (c) If a meeting is held upon less than 48 hours' notice, reasonable effort shall be made to have
 9 an interpreter present, but the requirement for an interpreter does not apply to emergency meetings.

10 (d) If certification of interpreters occurs under state or federal law, the Oregon Health Author-
 11 ity or other state or local agency shall [*try to*] **make a good faith effort to** refer only certified
 12 interpreters to governing bodies for purposes of this subsection.

13 (e) As used in this subsection, "good faith effort" [*includes, but is not limited to, contacting the*
 14 *department or other state or local agency that maintains a list of qualified interpreters and arranging*
 15 *for the referral of one or more qualified interpreters to provide interpreter services*] **means taking the**
 16 **steps prescribed by the authority by rule under ORS 413.558 (8).**

17 **SECTION 11.** ORS 414.572 is amended to read:

18 414.572. (1) The Oregon Health Authority shall adopt by rule the qualification criteria and re-
 19 quirements for a coordinated care organization and shall integrate the criteria and requirements
 20 into each contract with a coordinated care organization. Coordinated care organizations may be
 21 local, community-based organizations or statewide organizations with community-based participation
 22 in governance or any combination of the two. Coordinated care organizations may contract with
 23 counties or with other public or private entities to provide services to members. The authority may
 24 not contract with only one statewide organization. A coordinated care organization may be a single
 25 corporate structure or a network of providers organized through contractual relationships. The cri-
 26 teria and requirements adopted by the authority under this section must include, but are not limited
 27 to, a requirement that the coordinated care organization:

28 (a) Have demonstrated experience and a capacity for managing financial risk and establishing
 29 financial reserves.

30 (b) Meet the following minimum financial requirements:

31 (A) Maintain restricted reserves of \$250,000 plus an amount equal to 50 percent of the coordi-
 32 nated care organization's total actual or projected liabilities above \$250,000.

33 (B) Maintain capital or surplus of not less than \$2,500,000 and any additional amounts necessary
 34 to ensure the solvency of the coordinated care organization, as specified by the authority by rules
 35 that are consistent with ORS 731.554 (6), 732.225, 732.230 and 750.045.

36 (C) Expend a portion of the annual net income or reserves of the coordinated care organization
 37 that exceed the financial requirements specified in this paragraph on services designed to address
 38 health disparities and the social determinants of health consistent with the coordinated care
 39 organization's community health improvement plan and transformation plan and the terms and con-
 40 ditions of the Medicaid demonstration project under section 1115 of the Social Security Act (42
 41 U.S.C. 1315).

42 (c) Operate within a fixed global budget and, by January 1, 2023, spend on primary care, as de-
 43 fined in section 2, chapter 575, Oregon Laws 2015, at least 12 percent of the coordinated care
 44 organization's total expenditures for physical and mental health care provided to members, except
 45 for expenditures on prescription drugs, vision care and dental care.

1 (d) Develop and implement alternative payment methodologies that are based on health care
2 quality and improved health outcomes.

3 (e) Coordinate the delivery of physical health care, mental health and chemical dependency
4 services, oral health care and covered long-term care services.

5 (f) Engage community members and health care providers in improving the health of the com-
6 munity and addressing regional, cultural, socioeconomic and racial disparities in health care that
7 exist among the coordinated care organization’s members and in the coordinated care organization’s
8 community.

9 (2) In addition to the criteria and requirements specified in subsection (1) of this section, the
10 authority must adopt by rule requirements for coordinated care organizations contracting with the
11 authority so that:

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

14 (b) Each member has a consistent and stable relationship with a care team that is responsible
15 for comprehensive care management and service delivery.

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

20 (d) Members receive comprehensive transitional care, including appropriate follow-up, when en-
21 tering and leaving an acute care facility or a long term care setting.

22 (e) Members receive assistance in navigating the health care delivery system, **receive assist-**
23 **ance** [and] in accessing community and social support services and statewide resources[, *including*
24 *through the use of*] **and have available to them** certified health care interpreters and qualified
25 health care interpreters **from the health care interpreter registry**, as those terms are defined in
26 ORS 413.550.

27 (f) Services and supports are geographically located as close to where members reside as possi-
28 ble and are, if available, offered in nontraditional settings that are accessible to families, diverse
29 communities and underserved populations.

30 (g) Each coordinated care organization uses health information technology to link services and
31 care providers across the continuum of care to the greatest extent practicable and if financially vi-
32 able.

33 (h) Each coordinated care organization complies with the safeguards for members described in
34 ORS 414.605.

35 (i) Each coordinated care organization convenes a community advisory council that meets the
36 criteria specified in ORS 414.575.

37 (j) Each coordinated care organization prioritizes working with members who have high health
38 care needs, multiple chronic conditions, mental illness or chemical dependency and involves those
39 members in accessing and managing appropriate preventive, health, remedial and supportive care
40 and services, including the services described in ORS 414.766, to reduce the use of avoidable emer-
41 gency room visits and hospital admissions.

42 (k) Members have a choice of providers within the coordinated care organization’s network and
43 that providers participating in a coordinated care organization:

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

1 (B) Are educated about the integrated approach and how to access and communicate within the
2 integrated system about a patient's treatment plan and health history.

3 (C) Emphasize prevention, healthy lifestyle choices, evidence-based practices, shared decision-
4 making and communication.

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

6 (E) Include providers of specialty care.

7 (F) Are selected by coordinated care organizations using universal application and credentialing
8 procedures and objective quality information and are removed if the providers fail to meet objective
9 quality standards.

10 (G) Work together to develop best practices for culturally appropriate care and service delivery
11 to reduce waste, reduce health disparities and improve the health and well-being of members.

12 (L) Each coordinated care organization reports on outcome and quality measures adopted under
13 ORS 414.638 and participates in the health care data reporting system established in ORS 442.372
14 and 442.373.

15 (m) Each coordinated care organization uses best practices in the management of finances,
16 contracts, claims processing, payment functions and provider networks.

17 (n) Each coordinated care organization participates in the learning collaborative described in
18 ORS 413.259 (3).

19 (o) Each coordinated care organization has a governing body that complies with ORS 414.584
20 and that includes:

21 (A) At least one member representing persons that share in the financial risk of the organiza-
22 tion;

23 (B) A representative of a dental care organization selected by the coordinated care organization;

24 (C) The major components of the health care delivery system;

25 (D) At least two health care providers in active practice, including:

26 (i) A physician licensed under ORS chapter 677 or a nurse practitioner licensed under ORS
27 678.375, whose area of practice is primary care; and

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

29 (E) At least two members from the community at large, to ensure that the organization's
30 decision-making is consistent with the values of the members and the community; and

31 (F) At least two members of the community advisory council, one of whom is or was within the
32 previous six months a recipient of medical assistance and is at least 16 years of age, or a parent,
33 guardian or primary caregiver of an individual who is or was within the previous six months a re-
34 cipient of medical assistance.

35 (p) Each coordinated care organization's governing body establishes standards for publicizing
36 the activities of the coordinated care organization and the organization's community advisory
37 councils, as necessary, to keep the community informed.

38 (q) Each coordinated care organization publishes on a website maintained by or on behalf of the
39 coordinated care organization, in a manner determined by the authority, a document designed to
40 educate members about best practices, care quality expectations, screening practices, treatment
41 options and other support resources available for members who have mental illnesses or substance
42 use disorders.

43 (r) Each coordinated care organization works with the Tribal Advisory Council established in
44 ORS 414.581 and has a dedicated tribal liaison, selected by the council, to:

45 (A) Facilitate a resolution of any issues that arise between the coordinated care organization

1 and a provider of Indian health services within the area served by the coordinated care organiza-
 2 tion;

3 (B) Participate in the community health assessment and the development of the health im-
 4 provement plan;

5 (C) Communicate regularly with the Tribal Advisory Council; and

6 (D) Be available for training by the office within the authority that is responsible for tribal af-
 7 fairs, any federally recognized tribe in Oregon and the urban Indian health program that is located
 8 within the area served by the coordinated care organization and operated by an urban Indian or-
 9 ganization pursuant to 25 U.S.C. 1651.

10 (3) The authority shall consider the participation of area agencies and other nonprofit agencies
 11 in the configuration of coordinated care organizations.

12 (4) In selecting one or more coordinated care organizations to serve a geographic area, the au-
 13 thority shall:

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

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

16 (c) Allow more than one coordinated care organization to serve the geographic area if necessary
 17 to optimize access and choice under this subsection.

18 (5) On or before July 1, 2014, each coordinated care organization must have a formal contractual
 19 relationship with any dental care organization that serves members of the coordinated care organ-
 20 ization in the area where they reside.

21 **SECTION 12.** ORS 414.572, as amended by section 14, chapter 489, Oregon Laws 2017, section
 22 4, chapter 49, Oregon Laws 2018, section 8, chapter 358, Oregon Laws 2019, section 2, chapter 364,
 23 Oregon Laws 2019, section 58, chapter 478, Oregon Laws 2019, and section 7, chapter 529, Oregon
 24 Laws 2019, is amended to read:

25 414.572. (1) The Oregon Health Authority shall adopt by rule the qualification criteria and re-
 26 quirements for a coordinated care organization and shall integrate the criteria and requirements
 27 into each contract with a coordinated care organization. Coordinated care organizations may be
 28 local, community-based organizations or statewide organizations with community-based participation
 29 in governance or any combination of the two. Coordinated care organizations may contract with
 30 counties or with other public or private entities to provide services to members. The authority may
 31 not contract with only one statewide organization. A coordinated care organization may be a single
 32 corporate structure or a network of providers organized through contractual relationships. The cri-
 33 teria and requirements adopted by the authority under this section must include, but are not limited
 34 to, a requirement that the coordinated care organization:

35 (a) Have demonstrated experience and a capacity for managing financial risk and establishing
 36 financial reserves.

37 (b) Meet the following minimum financial requirements:

38 (A) Maintain restricted reserves of \$250,000 plus an amount equal to 50 percent of the coordi-
 39 nated care organization's total actual or projected liabilities above \$250,000.

40 (B) Maintain capital or surplus of not less than \$2,500,000 and any additional amounts necessary
 41 to ensure the solvency of the coordinated care organization, as specified by the authority by rules
 42 that are consistent with ORS 731.554 (6), 732.225, 732.230 and 750.045.

43 (C) Expend a portion of the annual net income or reserves of the coordinated care organization
 44 that exceed the financial requirements specified in this paragraph on services designed to address
 45 health disparities and the social determinants of health consistent with the coordinated care

1 organization's community health improvement plan and transformation plan and the terms and con-
2 ditions of the Medicaid demonstration project under section 1115 of the Social Security Act (42
3 U.S.C. 1315).

4 (c) Operate within a fixed global budget and spend on primary care, as defined by the authority
5 by rule, at least 12 percent of the coordinated care organization's total expenditures for physical
6 and mental health care provided to members, except for expenditures on prescription drugs, vision
7 care and dental care.

8 (d) Develop and implement alternative payment methodologies that are based on health care
9 quality and improved health outcomes.

10 (e) Coordinate the delivery of physical health care, mental health and chemical dependency
11 services, oral health care and covered long-term care services.

12 (f) Engage community members and health care providers in improving the health of the com-
13 munity and addressing regional, cultural, socioeconomic and racial disparities in health care that
14 exist among the coordinated care organization's members and in the coordinated care organization's
15 community.

16 (2) In addition to the criteria and requirements specified in subsection (1) of this section, the
17 authority must adopt by rule requirements for coordinated care organizations contracting with the
18 authority so that:

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

21 (b) Each member has a consistent and stable relationship with a care team that is responsible
22 for comprehensive care management and service delivery.

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

27 (d) Members receive comprehensive transitional care, including appropriate follow-up, when en-
28 tering and leaving an acute care facility or a long term care setting.

29 (e) Members receive assistance in navigating the health care delivery system, **receive assist-**
30 **ance** [*and*] in accessing community and social support services and statewide resources[, *including*
31 *through the use of*] **and have available to them** certified health care interpreters and qualified
32 health care interpreters **from the health care interpreter registry**, as those terms are defined in
33 ORS 413.550.

34 (f) Services and supports are geographically located as close to where members reside as possi-
35 ble and are, if available, offered in nontraditional settings that are accessible to families, diverse
36 communities and underserved populations.

37 (g) Each coordinated care organization uses health information technology to link services and
38 care providers across the continuum of care to the greatest extent practicable and if financially vi-
39 able.

40 (h) Each coordinated care organization complies with the safeguards for members described in
41 ORS 414.605.

42 (i) Each coordinated care organization convenes a community advisory council that meets the
43 criteria specified in ORS 414.575.

44 (j) Each coordinated care organization prioritizes working with members who have high health
45 care needs, multiple chronic conditions, mental illness or chemical dependency and involves those

1 members in accessing and managing appropriate preventive, health, remedial and supportive care
 2 and services, including the services described in ORS 414.766, to reduce the use of avoidable emer-
 3 gency room visits and hospital admissions.

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

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

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

10 (C) Emphasize prevention, healthy lifestyle choices, evidence-based practices, shared decision-
 11 making and communication.

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

13 (E) Include providers of specialty care.

14 (F) Are selected by coordinated care organizations using universal application and credentialing
 15 procedures and objective quality information and are removed if the providers fail to meet objective
 16 quality standards.

17 (G) Work together to develop best practices for culturally appropriate care and service delivery
 18 to reduce waste, reduce health disparities and improve the health and well-being of members.

19 (L) Each coordinated care organization reports on outcome and quality measures adopted under
 20 ORS 414.638 and participates in the health care data reporting system established in ORS 442.372
 21 and 442.373.

22 (m) Each coordinated care organization uses best practices in the management of finances,
 23 contracts, claims processing, payment functions and provider networks.

24 (n) Each coordinated care organization participates in the learning collaborative described in
 25 ORS 413.259 (3).

26 (o) Each coordinated care organization has a governing body that complies with ORS 414.584
 27 and that includes:

28 (A) At least one member representing persons that share in the financial risk of the organiza-
 29 tion;

30 (B) A representative of a dental care organization selected by the coordinated care organization;

31 (C) The major components of the health care delivery system;

32 (D) At least two health care providers in active practice, including:

33 (i) A physician licensed under ORS chapter 677 or a nurse practitioner licensed under ORS
 34 678.375, whose area of practice is primary care; and

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

36 (E) At least two members from the community at large, to ensure that the organization’s
 37 decision-making is consistent with the values of the members and the community; and

38 (F) At least two members of the community advisory council, one of whom is or was within the
 39 previous six months a recipient of medical assistance and is at least 16 years of age or a parent,
 40 guardian or primary caregiver of an individual who is or was within the previous six months a re-
 41 cipient of medical assistance.

42 (p) Each coordinated care organization’s governing body establishes standards for publicizing
 43 the activities of the coordinated care organization and the organization’s community advisory
 44 councils, as necessary, to keep the community informed.

45 (q) Each coordinated care organization publishes on a website maintained by or on behalf of the

1 coordinated care organization, in a manner determined by the authority, a document designed to
 2 educate members about best practices, care quality expectations, screening practices, treatment
 3 options and other support resources available for members who have mental illnesses or substance
 4 use disorders.

5 (r) Each coordinated care organization works with the Tribal Advisory Council established in
 6 ORS 414.581 and has a dedicated tribal liaison, selected by the council, to:

7 (A) Facilitate a resolution of any issues that arise between the coordinated care organization
 8 and a provider of Indian health services within the area served by the coordinated care organiza-
 9 tion;

10 (B) Participate in the community health assessment and the development of the health im-
 11 provement plan;

12 (C) Communicate regularly with the Tribal Advisory Council; and

13 (D) Be available for training by the office within the authority that is responsible for tribal af-
 14 fairs, any federally recognized tribe in Oregon and the urban Indian health program that is located
 15 within the area served by the coordinated care organization and operated by an urban Indian or-
 16 ganization pursuant to 25 U.S.C. 1651.

17 (3) The authority shall consider the participation of area agencies and other nonprofit agencies
 18 in the configuration of coordinated care organizations.

19 (4) In selecting one or more coordinated care organizations to serve a geographic area, the au-
 20 thority shall:

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

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

23 (c) Allow more than one coordinated care organization to serve the geographic area if necessary
 24 to optimize access and choice under this subsection.

25 (5) On or before July 1, 2014, each coordinated care organization must have a formal contractual
 26 relationship with any dental care organization that serves members of the coordinated care organ-
 27 ization in the area where they reside.

28 **SECTION 13.** ORS 656.027 is amended to read:

29 656.027. All workers are subject to this chapter except those nonsubject workers described in
 30 the following subsections:

31 (1) A worker employed as a domestic servant in or about a private home. For the purposes of
 32 this subsection “domestic servant” means any worker engaged in household domestic service by
 33 private employment contract, including, but not limited to, home health workers.

34 (2) A worker employed to do gardening, maintenance, repair, remodeling or similar work in or
 35 about the private home of the person employing the worker.

36 (3)(a) A worker whose employment is casual and either:

37 (A) The employment is not in the course of the trade, business or profession of the employer;

38 or

39 (B) The employment is in the course of the trade, business or profession of a nonsubject em-
 40 ployer.

41 (b) For the purpose of this subsection, “casual” refers only to employments where the work in
 42 any 30-day period, without regard to the number of workers employed, involves a total labor cost
 43 of less than \$500.

44 (4) A person for whom a rule of liability for injury or death arising out of and in the course of
 45 employment is provided by the laws of the United States.

1 (5) A worker engaged in the transportation in interstate commerce of goods, persons or property
 2 for hire by rail, water, aircraft or motor vehicle, and whose employer has no fixed place of business
 3 in this state.

4 (6) Firefighter and police employees of any city having a population of more than 200,000 that
 5 provides a disability and retirement system by ordinance or charter.

6 (7)(a) Sole proprietors, except those described in paragraph (b) of this subsection. When labor
 7 or services are performed under contract, the sole proprietor must qualify as an independent con-
 8 tractor **to be a nonsubject worker.**

9 (b) Sole proprietors actively licensed under ORS 671.525 or 701.021. When labor or services are
 10 performed under contract for remuneration, notwithstanding ORS 656.005 (30), the sole proprietor
 11 must qualify as an independent contractor. Any sole proprietor licensed under ORS 671.525 or
 12 701.021 and involved in activities subject thereto is conclusively presumed to be an independent
 13 contractor.

14 (8) Except as provided in subsection (23) of this section, partners who are not engaged in work
 15 performed in direct connection with the construction, alteration, repair, improvement, moving or
 16 demolition of an improvement on real property or appurtenances thereto. When labor or services
 17 are performed under contract, the partnership must qualify as an independent contractor **to be a**
 18 **nonsubject worker.**

19 (9) Except as provided in subsection (25) of this section, members, including members who are
 20 managers, of limited liability companies, regardless of the nature of the work performed. However,
 21 members, including members who are managers, of limited liability companies with more than one
 22 member, while engaged in work performed in direct connection with the construction, alteration,
 23 repair, improvement, moving or demolition of an improvement on real property or appurtenances
 24 thereto, are subject workers. When labor or services are performed under contract, the limited li-
 25 ability company must qualify as an independent contractor **to be a nonsubject worker.**

26 (10) Except as provided in subsection (24) of this section, corporate officers who are directors
 27 of the corporation and who have a substantial ownership interest in the corporation, regardless of
 28 the nature of the work performed by such officers, subject to the following limitations:

29 (a) If the activities of the corporation are conducted on land that receives farm use tax assess-
 30 ment pursuant to ORS chapter 308A, corporate officer includes all individuals identified as directors
 31 in the corporate bylaws, regardless of ownership interest, and who are members of the same family,
 32 whether related by blood, marriage or adoption.

33 (b) If the activities of the corporation involve the commercial harvest of timber and all officers
 34 of the corporation are members of the same family and are parents, daughters or sons, daughters-
 35 in-law or sons-in-law or grandchildren, then all such officers may elect to be nonsubject workers.
 36 For all other corporations involving the commercial harvest of timber, the maximum number of ex-
 37 empt corporate officers for the corporation shall be whichever is the greater of the following:

38 (A) Two corporate officers; or

39 (B) One corporate officer for each 10 corporate employees.

40 (c) When labor or services are performed under contract, the corporation must qualify as an
 41 independent contractor **to be a nonsubject worker.**

42 (11) A person performing services primarily for board and lodging received from any religious,
 43 charitable or relief organization.

44 (12) A newspaper carrier utilized in compliance with the provisions of ORS 656.070 and 656.075.

45 (13) A person who has been declared an amateur athlete under the rules of the United States

1 Olympic Committee or the Canadian Olympic Committee and who receives no remuneration for
 2 performance of services as an athlete other than board, room, rent, housing, lodging or other rea-
 3 sonable incidental subsistence allowance, or any amateur sports official who is certified by a re-
 4 cognized Oregon or national certifying authority, which requires or provides liability and accident
 5 insurance for such officials. A roster of recognized Oregon and national certifying authorities will
 6 be maintained by the Department of Consumer and Business Services, from lists of certifying or-
 7 ganizations submitted by the Oregon School Activities Association and the Oregon Park and Re-
 8 creation Society.

9 (14) Volunteer personnel participating in the ACTION programs, organized under the Domestic
 10 Volunteer Service Act of 1973, P.L. 93-113, known as the Foster Grandparent Program and the
 11 Senior Companion Program, whether or not the volunteers receive a stipend or nominal reimburse-
 12 ment for time and travel expenses.

13 (15) A person who has an ownership or leasehold interest in equipment and who furnishes,
 14 maintains and operates the equipment. As used in this subsection "equipment" means:

15 (a) A motor vehicle used in the transportation of logs, poles or piling.

16 (b) A motor vehicle used in the transportation of rocks, gravel, sand, dirt or asphalt concrete.

17 (c) A motor vehicle used in the transportation of property by a for-hire motor carrier that is
 18 required under ORS 825.100 or 825.104 to possess a certificate or permit or to be registered.

19 (16) A person engaged in the transportation of the public for recreational down-river boating
 20 activities on the waters of this state pursuant to a federal permit when the person furnishes the
 21 equipment necessary for the activity. As used in this subsection, "recreational down-river boating
 22 activities" means those boating activities for the purpose of recreational fishing, swimming or
 23 sightseeing utilizing a float craft with oars or paddles as the primary source of power.

24 (17) A person who receives no wage other than ski passes or other noncash remuneration for
 25 performing volunteer:

26 (a) Ski patrol activities; or

27 (b) Ski area program activities sponsored by a ski area operator, as defined in ORS 30.970, or
 28 by a nonprofit corporation or organization.

29 (18) A person 19 years of age or older who contracts with a newspaper publishing company or
 30 independent newspaper dealer or contractor to distribute newspapers to the general public and
 31 perform or undertake any necessary or attendant functions related thereto.

32 (19) A person performing foster parent or adult foster care duties pursuant to ORS 412.001 to
 33 412.161 and 412.991 or ORS chapter [411,] 418, 430 or 443.

34 (20) A person performing services on a volunteer basis for a nonprofit, religious, charitable or
 35 relief organization, whether or not such person receives meals or lodging or nominal reimbursements
 36 or vouchers for meals, lodging or expenses.

37 (21) A person performing services under a property tax work-off program established under ORS
 38 310.800.

39 (22) A person who performs service as a caddy at a golf course in an established program for
 40 the training and supervision of caddies under the direction of a person who is an employee of the
 41 golf course.

42 (23)(a) Partners who are actively licensed under ORS 671.525 or 701.021 and who have a sub-
 43 stantial ownership interest in a partnership. If all partners are members of the same family and are
 44 parents, spouses, sisters, brothers, daughters or sons, daughters-in-law or sons-in-law or grandchil-
 45 dren, all such partners may elect to be nonsubject workers. For all other partnerships licensed un-

1 der ORS 671.510 to 671.760 or 701.021, the maximum number of exempt partners shall be whichever
 2 is the greater of the following:

3 (A) Two partners; or

4 (B) One partner for each 10 partnership employees.

5 (b) When labor or services are performed under contract for remuneration, notwithstanding ORS
 6 656.005 (30), the partnership qualifies as an independent contractor. Any partnership licensed under
 7 ORS 671.525 or 701.021 and involved in activities subject thereto is conclusively presumed to be an
 8 independent contractor.

9 (24)(a) Corporate officers who are directors of a corporation actively licensed under ORS 671.525
 10 or 701.021 and who have a substantial ownership interest in the corporation, regardless of the na-
 11 ture of the work performed. If all officers of the corporation are members of the same family and
 12 are parents, spouses, sisters, brothers, daughters or sons, daughters-in-law or sons-in-law or grand-
 13 children, all such officers may elect to be nonsubject workers. For all other corporations licensed
 14 under ORS 671.510 to 671.760 or 701.021, the maximum number of exempt corporate officers shall
 15 be whichever is the greater of the following:

16 (A) Two corporate officers; or

17 (B) One corporate officer for each 10 corporate employees.

18 (b) When labor or services are performed under contract for remuneration, notwithstanding ORS
 19 656.005 (30), the corporation qualifies as an independent contractor. Any corporation licensed under
 20 ORS 671.525 or 701.021 and involved in activities subject thereto is conclusively presumed to be an
 21 independent contractor.

22 (25)(a) Limited liability company members who are members of a company actively licensed un-
 23 der ORS 671.525 or 701.021 and who have a substantial ownership interest in the company, regard-
 24 less of the nature of the work performed. If all members of the company are members of the same
 25 family and are parents, spouses, sisters, brothers, daughters or sons, daughters-in-law or sons-in-law
 26 or grandchildren, all such members may elect to be nonsubject workers. For all other companies
 27 licensed under ORS 671.510 to 671.760 or 701.021, the maximum number of exempt company members
 28 shall be whichever is the greater of the following:

29 (A) Two company members; or

30 (B) One company member for each 10 company employees.

31 (b) When labor or services are performed under contract for remuneration, notwithstanding ORS
 32 656.005 (30), the company qualifies as an independent contractor. Any company licensed under ORS
 33 671.525 or 701.021 and involved in activities subject thereto is conclusively presumed to be an in-
 34 dependent contractor.

35 (26) A person serving as a referee or assistant referee in a youth or adult recreational soccer
 36 match whose services are retained on a match-by-match basis.

37 *[(27) A person performing language translator or interpreter services that are provided for others*
 38 *through an agent or broker.]*

39 *[(28)]* **(27)** A person who operates, and who has an ownership or leasehold interest in, a pas-
 40 senger motor vehicle that is operated as a taxicab or for nonemergency medical transportation.
 41 As used in this subsection:

42 (a) "Lease" means a contract under which the lessor provides a vehicle to a lessee for consid-
 43 eration.

44 (b) "Leasehold" includes, but is not limited to, a lease for a shift or a longer period.

45 (c) "Passenger motor vehicle that is operated as a taxicab" means a vehicle that:

1 (A) Has a passenger seating capacity that does not exceed seven persons;

2 (B) Is transporting persons, property or both on a route that begins or ends in Oregon; and

3 (C)(i) Carries passengers for hire when the destination and route traveled may be controlled by
4 a passenger and the fare is calculated on the basis of any combination of an initial fee, distance
5 traveled or waiting time; or

6 (ii) Is in use under a contract to provide specific service to a third party to transport designated
7 passengers or to provide errand services to locations selected by the third party.

8 (d) "Passenger motor vehicle that is operated for nonemergency medical transportation" means
9 a vehicle that:

10 (A) Has a passenger seating capacity that does not exceed seven persons;

11 (B) Is transporting persons, property or both on a route that begins or ends in Oregon; and

12 (C) Provides medical transportation services under contract with or on behalf of a mass transit
13 or transportation district.

14 **SECTION 14.** ORS 657.046 is amended to read:

15 657.046. (1) As used in this chapter, "employment" does not include service performed in the
16 operation of a passenger motor vehicle that is operated as a taxicab or a passenger motor vehicle
17 that is operated for nonemergency medical transportation, by a person who has an ownership or
18 leasehold interest in the passenger motor vehicle, for an entity that is operated by a board of
19 owner-operators elected by the members of the entity.

20 (2) As used in this section:

21 (a) "Leasehold" has the meaning given that term in ORS 656.027 [(28)] (27).

22 (b) "Passenger motor vehicle that is operated as a taxicab" means a vehicle that:

23 (A) Has a passenger seating capacity of at least three persons and not more than seven persons;

24 (B) On a route that begins or ends in Oregon, is used primarily to transport persons;

25 (C)(i) Carries passengers for hire when the destination and route traveled may be controlled by
26 a passenger and the fare is calculated on the basis of any combination of an initial fee, distance
27 traveled or waiting time; or

28 (ii) Is in use under a contract to provide specific service to a third party to transport designated
29 passengers to locations selected by the third party; and

30 (D) Is not used more than secondarily or incidentally for errand services or to transport prop-
31 erty, instead of or in addition to transporting passengers.

32 (c) "Passenger motor vehicle that is operated for nonemergency medical transportation" means
33 a vehicle that:

34 (A) Has a passenger seating capacity of at least three persons and not more than seven persons;

35 (B) On a route that begins or ends in Oregon, is used primarily to transport persons;

36 (C) Provides medical transportation services under contract with or on behalf of a mass transit
37 or transportation district; and

38 (D) Is not used more than secondarily or incidentally for errand services or to transport prop-
39 erty, instead of or in addition to transporting passengers.

40 (3) The provisions of this section do not apply to service performed for:

41 (a) A nonprofit employing unit;

42 (b) This state;

43 (c) A political subdivision of this state; or

44 (d) An Indian tribe.

45 **SECTION 15.** Section 3 of this 2020 Act is amended to read:

1 **Sec. 3.** (1) With the advice of the Oregon Council on Health Care Interpreters, the Oregon
2 Health Authority shall implement by rule policies and processes to hold accountable:

3 (a) Interpretation service companies and health care providers for using only qualified or certi-
4 fied health care interpreters; and

5 (b) Health care interpreters and health care interpreter training programs for the quality of in-
6 terpretation services provided.

7 (2) The policies and procedures must include, at a minimum:

8 (a) Investigating and resolving complaints about:

9 (A) The failure of interpretation service companies and health care providers to use qualified
10 or certified health care interpreters;

11 (B) Interpretation service companies in regard to unfair labor or contracting practices, dis-
12 crimination, violation of consumer protections, risks to the health or safety of patients, conflicts of
13 interest or compliance with law; and

14 (C) Health care interpreters in regard to discrimination, risks to the health or safety of patients,
15 conflicts of interest or scope of practice.

16 (b) [*No later than January 1, 2022,*] Collaborating with the Bureau of Labor and Industries or
17 the Department of Justice, as appropriate, to investigate complaints filed under this section and
18 impose appropriate remedial measures or civil penalties in accordance with ORS 183.745. Health
19 care interpreters may be subject to suspension or revocation of their qualification or certification
20 but not to civil penalties.

21 (c) Tracking state expenditures on providing health care interpretation services and the portion
22 of the expenditures that are spent on administrative costs.

23 **SECTION 16.** (1) Sections 4 and 5 of this 2020 Act and the amendments to ORS 413.550,
24 413.552, 413.556 and 414.572 by sections 6 to 8, 11 and 12 of this 2020 Act become operative on
25 September 1, 2020.

26 (2) Sections 2 and 3 of this 2020 Act and the amendments to ORS 413.552 by section 7 of
27 this 2020 Act become operative on January 1, 2021.

28 (3) Section 3 of this 2020 Act, as amended by section 15 of this 2020 Act, becomes opera-
29 tive on January 1, 2022.

30 **SECTION 17.** This 2020 Act being necessary for the immediate preservation of the public
31 peace, health and safety, an emergency is declared to exist, and this 2020 Act takes effect
32 on its passage.
33