LC 2075
2025 Regular Session
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D R A F T

SUMMARY

Digest: The Act makes changes relating to Oregon's CCOs. (Flesch Readability Score: 61.2).

Modifies the factors that the Oregon Health Authority must take into consideration when determining a global budget for a coordinated care organization. Directs the authority to collaborate with coordinated care organizations to standardize the rules and systems used in delivering health-related social needs services. Directs the authority to seek federal approval to administer the prioritized list of health services through an amendment to the Medicaid state plan.

A BILL FOR AN ACT

Relating to coordinated care organizations; creating new provisions; and amending ORS 414.065, 414.570, 414.572, 414.690 and 414.855.

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

SECTION 1. ORS 414.570 is amended to read:

414.570. (1) There is established the Oregon Integrated and Coordinated Health Care Delivery System. The **purpose of the** system [*shall consist of state policies and actions that make*] **is to:**

(a) Fundamentally change how health care is delivered to expand access to care, improve the quality of care and reduce the cost of care provided to medical assistance recipients; and

(b) Focus on the health and not just the health care of medical assistance recipients by addressing the social determinants of health.

(2) Coordinated care organizations [*accountable*] **shall be a single point of accountability** for care management and **the** provision of integrated [*and*]**,** coordinated **and accessible** health care for each organization's mem-

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.

bers, primarily managed within fixed global budgets, by providing care so that efficiency and quality improvements reduce medical cost inflation while supporting the development of regional and community accountability for the health of the residents of each region and community, and while maintaining regulatory controls necessary to ensure quality and affordable health care for all Oregonians.

[*(2)*] **(3)** The Oregon Health Authority shall seek input from groups and individuals who are part of underserved communities, including ethnically diverse populations, geographically isolated groups, seniors, people with disabilities and people using mental health services, and shall also seek input from providers, coordinated care organizations and communities, in the development of strategies that promote person centered care and encourage healthy behaviors, healthy lifestyles and prevention and wellness activities and promote the development of patients' skills in self-management and illness management.

[*(3)*] **(4)** The authority shall regularly report to the Oregon Health Policy Board, the Governor and the Legislative Assembly on the progress of payment reform and delivery system change including:

(a) The achievement of benchmarks;

(b) Progress toward eliminating health disparities;

(c) Results of evaluations;

(d) Rules adopted;

(e) Customer satisfaction;

(f) Use of patient centered primary care homes and behavioral health homes;

(g) The involvement of local governments in governance and service delivery; and

(h) Other developments with respect to coordinated care organizations.

SECTION 2. ORS 414.065, as amended by section 1, chapter 18, Oregon Laws 2024, is amended to read:

414.065. (1)(a) Consistent with ORS 414.690, 414.710, 414.712 and 414.766

and other statutes governing the provision of and payments for health services in medical assistance, the Oregon Health Authority shall determine, subject to such revisions as it may make from time to time and to legislative funding:

(A) The types and extent of health services to be provided to each eligible group of recipients of medical assistance.

(B) Standards, including outcome and quality measures, to be observed in the provision of health services.

(C) The number of days of health services toward the cost of which medical assistance funds will be expended in the care of any person.

(D) Reasonable fees, charges, daily rates and global payments for meeting the costs of providing health services to an applicant or recipient.

(E) Reasonable fees for professional medical and dental services which may be based on usual and customary fees in the locality for similar services.

(F) The amount and application of any copayment or other similar cost-sharing payment that the authority may require a recipient to pay toward the cost of health services.

(b) The authority shall adopt rules establishing timelines for payment of health services under paragraph (a) of this subsection.

(2) In making the determinations under subsection (1) of this section and in the imposition of any utilization controls on access to health services, the authority may not consider a quality of life in general measure, either directly or by considering a source that relies on a quality of life in general measure.

(3) The types and extent of health services and the amounts to be paid in meeting the costs thereof, as determined and fixed by the authority and within the limits of funds available therefor, shall be the total available for medical assistance, and payments for such medical assistance shall be the total amounts from medical assistance funds available to providers of health services in meeting the costs thereof.

(4) Except for payments under a cost-sharing plan, payments made by the

authority for medical assistance shall constitute payment in full for all health services for which such payments of medical assistance were made.

(5) Notwithstanding subsection (1) of this section, the Department of Human Services shall be responsible for determining the payment for Medicaid-funded long term care services and for contracting with the providers of long term care services.

(6) In determining a global budget for a coordinated care organization:

(a) The allocation of the payment, the risk and any cost savings shall be determined by the governing body of the organization;

(b) The authority shall**:**

(A) Consider the community health assessment conducted by the organization in accordance with ORS 414.577 and reviewed annually, and **all evidence of** the organization's [*health care*] costs; [*and*]

[*(c)*] **(B)** [*The authority shall*] Take into account**:**

(i) The organization's provision of innovative, nontraditional health services**;**

(ii) The organization's efforts to improve health outcomes for the organization's members, including expenditures to improve health outcomes in future years;

(iii) The organization's efforts to improve the quality of and access to care;

(iv) The organization's efforts to reduce the delivery of inefficient and ineffectual care;

(v) The organization's expenses in support of short-term and long-term community health improvement; and

(vi) The organization's expenses in developing a sufficient network of providers to ensure access to care; and

(C) Allow the organization flexibility in spending Medicaid funds and making sustainable community health investments according to the priorities identified by the community the organization serves.

(7) Under the supervision of the Governor, the authority may work with

the Centers for Medicare and Medicaid Services to develop, in addition to global budgets, payment streams:

(a) To support improved delivery of health care to recipients of medical assistance; and

(b) That are funded by coordinated care organizations, counties or other entities other than the state whose contributions qualify for federal matching funds under Title XIX or XXI of the Social Security Act.

SECTION 3. ORS 414.690, as amended by section 3, chapter 18, Oregon Laws 2024, is amended to read:

414.690. (1) The Health Evidence Review Commission shall regularly solicit testimony and information from stakeholders representing consumers, advocates, providers, carriers and employers in conducting the work of the commission.

(2) The commission shall actively solicit public involvement through a public meeting process to guide health resource allocation decisions that includes, but is not limited to:

(a) Providing members of the public the opportunity to provide input on the selection of any vendor that provides research and analysis to the commission; and

(b) Inviting public comment on any research or analysis tool or health economic measures to be relied upon by the commission in the commission's decision-making.

(3)(a) The commission shall develop and maintain a list of health services ranked by priority, from the most important to the least important, representing the comparative benefits of each service to the population to be served.

(b) Except as provided in ORS 414.701, the commission may not rely upon any quality of life in general measures, either directly or by considering research or analysis that relies on a quality of life in general measure, in determining:

(A) Whether a service is cost-effective;

(B) Whether a service is recommended; or

(C) The value of a service.

(c) The list must be submitted by the commission pursuant to subsection (5) of this section and is not subject to alteration by any other state agency.

(4) In order to encourage effective and efficient medical evaluation and treatment, the commission:

(a) May include clinical practice guidelines in its prioritized list of services. The commission shall actively solicit testimony and information from the medical community and the public to build a consensus on clinical practice guidelines developed by the commission.

(b) May include statements of intent in its prioritized list of services. Statements of intent should give direction on coverage decisions where medical codes and clinical practice guidelines cannot convey the intent of the commission.

(c) Shall consider both the clinical effectiveness and cost-effectiveness of health services, including drug therapies, in determining their relative importance using peer-reviewed medical literature.

(d) Shall, to the extent possible, expand the use of ethnically and biologically diverse studies to update the prioritized list of services.

(5) The commission shall report the prioritized list of services to the Oregon Health Authority for budget determinations by July 1 of each even-numbered year.

(6) The commission shall make its report during each regular session of the Legislative Assembly and shall submit a copy of its report to the Governor, the Speaker of the House of Representatives and the President of the Senate and post to the Oregon Health Authority's website, along with a solicitation of public comment, an assessment of the impact on access to medically necessary treatment and services by persons with disabilities or chronic illnesses resulting from the commission's prior use of any quality of life in general measures or any research or analysis that referred to or relied upon a quality of life in general measure.

(7) The commission may alter the list during the interim only as follows:

(a) To make technical changes to correct errors and omissions;

(b) To accommodate changes due to advancements in medical technology or new data regarding health outcomes;

(c) To accommodate changes to clinical practice guidelines; and

(d) To add statements of intent that clarify the prioritized list.

(8) If a service is deleted or added during an interim and no new funding is required, the commission shall report to the Speaker of the House of Representatives and the President of the Senate. However, if a service to be added requires increased funding to avoid discontinuing another service, the commission shall report to the Emergency Board to request the funding.

(9) The prioritized list of services remains in effect for a two-year period beginning no earlier than October 1 of each odd-numbered year.

(10)(a) As used in this section, "peer-reviewed medical literature" means scientific studies printed in journals or other publications that publish original manuscripts only after the manuscripts have been critically reviewed by unbiased independent experts for scientific accuracy, validity and reliability.

(b) "Peer-reviewed medical literature" does not include internal publications of pharmaceutical manufacturers.

SECTION 4. Section 5 of this 2025 Act is added to and made a part of ORS chapter 414.

SECTION 5. The Oregon Health Authority shall:

(1) Collaborate with coordinated care organizations to clarify the role of coordinated care organizations in delivering health-related social needs services.

(2) Simplify and standardize the programs, rules and reporting and accounting systems used in the delivery of health-related social needs services.

SECTION 6. ORS 414.572 is amended to read:

414.572. (1) The Oregon Health Authority shall adopt by rule the quali-

fication criteria and requirements for a coordinated care organization and shall integrate the criteria and requirements into each contract with a coordinated care organization. Coordinated care organizations may be local, community-based organizations or statewide organizations with community-based participation in governance or any combination of the two. Coordinated care organizations may contract with counties or with other public or private entities to provide services to members. The authority may not contract with only one statewide organization. A coordinated care organization may be a single corporate structure or a network of providers organized through contractual relationships. The criteria and requirements adopted by the authority under this section must include, but are not limited to, a requirement that the coordinated care organization:

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

(b) Meet the following minimum financial requirements:

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

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

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

(c) Operate within a fixed global budget and other payment mechanisms described in subsection (6) of this section and spend on primary care, as de-

fined by the authority by rule, at least 12 percent of the coordinated care organization's total expenditures for physical and mental health care provided to members, except for expenditures on prescription drugs, vision care and dental care.

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

(e) Coordinate the delivery of physical health care, behavioral health care, oral health care and covered long-term care services.

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

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

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

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

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

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

(e) Members are provided:

(A) Assistance in navigating the health care delivery system;

(B) Assistance in accessing community and social support services and statewide resources;

(C) Meaningful language access as required by federal and state law including, but not limited to, 42 U.S.C. 18116, Title VI of the Civil Rights Act of 1964, Title VI Guidance issued by the United States Department of Justice and the National Standards for Culturally and Linguistically Appropriate Services in Health and Health Care as issued by the United States Department of Health and Human Services; and

(D) Qualified health care interpreters or certified health care interpreters listed on the health care interpreter registry, as those terms are defined in ORS 413.550.

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

(g) Each coordinated care organization uses health information technology to link services and care providers across the continuum of care to the greatest extent practicable and if financially viable.

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

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

(j) Each coordinated care organization prioritizes working with members who have high health care needs, multiple chronic conditions or behavioral health conditions and involves those members in accessing and managing appropriate preventive, health, remedial and supportive care and services, including the services described in ORS 414.766, to reduce the use of avoidable emergency room visits and hospital admissions.

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

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

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

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

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

(E) Include providers of specialty care.

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

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

(L) Each coordinated care organization reports on outcome and quality measures adopted under ORS 413.022 and participates in the health care data reporting system established in ORS 442.372 and 442.373.

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

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

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

(A) At least one member representing persons that share in the financial risk of the organization;

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

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

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

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

(ii) A behavioral health provider;

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

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

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

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

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

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

(B) Participate in the community health assessment and the development of the health improvement plan;

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

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

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

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

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

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

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

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

(6) In addition to global budgets, the authority may employ other payment mechanisms to reimburse coordinated care organizations for specified health services during limited periods of time if:

(a) Global budgets remain the primary means of reimbursing coordinated care organizations for care and services provided to the coordinated care organization's members;

(b) The other payment mechanisms are consistent with the legislative intent expressed in ORS 414.018 and the system design described in ORS 414.570 [*(1)*]; and

(c) The payment mechanisms are employed only for health-related social

needs services, such as housing supports, nutritional assistance and climate-related assistance, approved for the demonstration project under 42 U.S.C. 1315 by the Centers for Medicare and Medicaid Services.

SECTION 7. ORS 414.855 is amended to read:

414.855. (1) An assessment is imposed on the net revenue of each hospital in this state. The assessment shall be imposed at a rate determined by the Director of the Oregon Health Authority by rule that is the director's best estimate of the rate needed to fund the services and costs identified in ORS 414.869. The rate of assessment shall be imposed on the net revenue of each hospital subject to assessment. The director shall consult with representatives of hospitals before setting the assessment.

(2) Each assessment shall be reported on a form prescribed by the Oregon Health Authority and shall contain the information required to be reported by the authority. The assessment form shall be filed with the authority on or before the 45th day following the end of the calendar quarter for which the assessment is being reported. Except as provided in subsection (5) of this section, the hospital shall pay the assessment at the time the hospital files the assessment report. The payment shall accompany the report.

(3)(a) To the extent permitted by federal law, aggregate assessments imposed under this section may not exceed the total of the following amounts received by the hospitals that are reimbursed by Medicare based on diagnostic related groups:

(A) 30 percent of payments made to the hospitals on a fee-for-service basis by the authority for inpatient hospital services;

(B) 41 percent of payments made to the hospitals on a fee-for-service basis by the authority for outpatient hospital services; and

(C) Payments made to the hospitals using a payment methodology established by the authority that advances the goals of the Oregon Integrated and Coordinated Health Care Delivery System described in ORS 414.570 [*(3)*].

(b) Notwithstanding paragraph (a) of this subsection, aggregate assessments imposed under this section on or after July 1, 2015, may exceed the

total of the amounts described in paragraph (a) of this subsection to the extent necessary to compensate for any reduction of funding in the legislatively adopted budget for hospital services under ORS 414.591, 414.631 and 414.688 to 414.745.

(c) The director may impose a lower rate of assessment on type A hospitals and type B hospitals to take into account the hospitals' financial position.

(4) Notwithstanding subsection (3) of this section, a hospital is not guaranteed that any additional moneys paid to the hospital in the form of payments for services shall equal or exceed the amount of the assessment paid by the hospital.

(5)(a) The authority shall develop a schedule for collection of the assessment for the calendar quarter ending September 30, 2021, that will result in the collection occurring between December 15, 2021, and the time all Medicaid cost settlements are finalized for that calendar quarter.

(b) The authority shall prescribe by rule criteria for late payment of assessments.

SECTION 8. (1) The Oregon Health Authority shall request approval from the Centers for Medicare and Medicaid Services to administer the prioritized list of health services compiled by the Health Evidence Review Commission under ORS 414.690 through an amendment to the Medicaid state plan instead of through a demonstration project under section 1115 of the Social Security Act (42 U.S.C. 1315).

(2) No later than September 15, 2026, the authority shall report to the interim committees of the Legislative Assembly related to health on whether the Centers for Medicare and Medicaid Services has approved the request under subsection (1) of this section.

SECTION 9. (1) The Oregon Health Authority shall request approval from the Centers for Medicare and Medicaid Services to carry out the amendments to ORS 414.065 by section 2 of this 2025 Act.

(2) The authority shall notify the Legislative Counsel immediately

upon receipt of the approval or denial of the request under subsection (1) of this section.

SECTION 10. The amendments to ORS 414.065 by section 2 of this 2025 Act become operative on the date on which the Legislative Counsel receives notice of the federal approval as provided under section 9 of this 2025 Act.
