

HB 2211-A3
(LC 2563)
4/28/25 (RH/ps)

Requested by Senator PATTERSON

**PROPOSED AMENDMENTS TO
A-ENGROSSED HOUSE BILL 2211**

1 On page 10 of the printed A-engrossed bill, delete lines 39 through 45.

2 Delete pages 11 through 13.

3 On page 14, delete lines 1 through 20 and insert:

4 **“SECTION 3.** ORS 414.572 is amended to read:

5 “414.572. (1) The Oregon Health Authority shall adopt by rule the quali-
6 fication criteria and requirements for a coordinated care organization and
7 shall integrate the criteria and requirements into each contract with a co-
8 ordinated care organization. Coordinated care organizations may be local,
9 community-based organizations or statewide organizations with community-
10 based participation in governance or any combination of the two. Coordi-
11 nated care organizations may contract with counties or with other public or
12 private entities to provide services to members. The authority may not con-
13 tract with only one statewide organization. A coordinated care organization
14 may be a single corporate structure or a network of providers organized
15 through contractual relationships. The criteria and requirements adopted by
16 the authority under this section must include, but are not limited to, a re-
17 quirement that the coordinated care organization:

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

20 “(b) Meet the following minimum financial requirements:

21 “(A) Maintain restricted reserves of \$250,000 plus an amount equal to 50

1 percent of the coordinated care organization's total actual or projected li-
2 abilities above \$250,000.

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

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

14 “(c) Operate within a fixed global budget and other payment mechanisms
15 described in subsection (6) of this section and spend on primary care, as de-
16 fined by the authority by rule, at least 12 percent of the coordinated care
17 organization's total expenditures for physical and mental health care pro-
18 vided to members, except for expenditures on prescription drugs, vision care
19 and dental care.

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

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

24 “(f) Engage community members and health care providers in improving
25 the health of the community and addressing regional, cultural, socioeconomic
26 and racial disparities in health care that exist among the coordinated care
27 organization's members and in the coordinated care organization's commu-
28 nity.

29 “(2) In addition to the criteria and requirements specified in subsection
30 (1) of this section, the authority must adopt by rule requirements for coor-

1 dinated care organizations contracting with the authority so that:

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

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

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

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

15 “(e) Members are provided:

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

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

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

25 “(D) Qualified health care interpreters or certified health care interpret-
26 ers listed on the health care interpreter registry, as those terms are defined
27 in ORS 413.550.

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

1 populations.

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

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

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

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

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

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

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

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

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

27 “(E) Include providers of specialty care.

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

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

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

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

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

12 “(o) Each coordinated care organization has a governing body that com-
13 plies with ORS 414.584 and that includes:

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

16 “(B) A representative of a dental [*care organization*] **subcontractor** se-
17 lected by the coordinated care organization;

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

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

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

22 “(ii) A behavioral health provider;

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

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

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

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

11 “(r) Each coordinated care organization works with the Tribal Advisory
12 Council established in ORS 414.581 and has a dedicated tribal liaison, se-
13 lected by the council, to:

14 “(A) Facilitate a resolution of any issues that arise between the coordi-
15 nated care organization and a provider of Indian health services within the
16 area served by the coordinated care organization;

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

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

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

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

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

30 “(a) For members and potential members, optimize access to care and

1 choice of providers;

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

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

7 “(5)(a) *[On or before July 1, 2014, each coordinated care organization must*
8 *have a formal contractual relationship with any dental care organization that*
9 *serves members of the coordinated care organization in the area where they*
10 *reside.]* **The authority shall:**

11 **“(A) Adopt by rule the requirements for a dental subcontractor that**
12 **contracts with a coordinated care organization; and**

13 **“(B) Incorporate the requirements adopted under this subsection**
14 **into any contract entered into between the authority and a coordi-**
15 **nated care organization under this section.**

16 **“(b) The authority may not require a dental subcontractor that**
17 **contracts with a coordinated care organization to produce any report**
18 **or other information unless the requirement is:**

19 **“(A) Established by state or federal statute, rule or regulation; or**

20 **“(B) Included in a contract entered into between the authority and**
21 **a coordinated care organization.**

22 “(6) In addition to global budgets, the authority may employ other pay-
23 ment mechanisms to reimburse coordinated care organizations for specified
24 health services during limited periods of time if:

25 “(a) Global budgets remain the primary means of reimbursing coordinated
26 care organizations for care and services provided to the coordinated care
27 organization’s members;

28 “(b) The other payment mechanisms are consistent with the legislative
29 intent expressed in ORS 414.018 and the system design described in ORS
30 414.570 (1); and

1 “(c) The payment mechanisms are employed only for health-related social
2 needs services, such as housing supports, nutritional assistance and
3 climate-related assistance, approved for the demonstration project under 42
4 U.S.C. 1315 by the Centers for Medicare and Medicaid Services.”.

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