

Requested by Representative KOTEK

**PROPOSED AMENDMENTS TO  
A-ENGROSSED HOUSE BILL 2122**

1 On page 1 of the printed A-engrossed bill, line 3, delete “and 414.627” and  
2 insert “, 414.627 and 414.653”.

3 Delete lines 5 through 20 and delete pages 2 and 3.

4 On page 4, delete lines 1 through 16 and insert:

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

6 “414.625. (1) The Oregon Health Authority shall adopt by rule the quali-  
7 fication criteria and requirements for a coordinated care organization and  
8 shall integrate the criteria and requirements into each contract with a co-  
9 ordinated care organization. Coordinated care organizations may be local,  
10 community-based organizations or statewide organizations with community-  
11 based participation in governance or any combination of the two. Coordi-  
12 nated care organizations may contract with counties or with other public or  
13 private entities to provide services to members. The authority may not con-  
14 tract with only one statewide organization. A coordinated care organization  
15 may be a single corporate structure or a network of providers organized  
16 through contractual relationships. The criteria **and requirements** adopted  
17 by the authority under this section must include, but are not limited to, **a**  
18 **requirement that** the coordinated care [*organization’s demonstrated experi-*  
19 *ence and capacity for*] **organization:**

20 “(a) **Have demonstrated experience and a capacity for** managing fi-  
21 nancial risk and establishing financial reserves.

1 “(b) [*Meeting*] **Meet** the following minimum financial requirements:

2 “(A) [*Maintaining*] **Maintain** restricted reserves of \$250,000 plus an  
3 amount equal to 50 percent of the coordinated care organization’s total ac-  
4 tual or projected liabilities above \$250,000.

5 “(B) [*Maintaining*] **Maintain** a net worth in an amount equal to at least  
6 five percent of the average combined revenue in the prior two quarters of the  
7 participating health care entities.

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

15 “(c) [*Operating*] **Operate** within a fixed global budget.

16 “(d) [*Developing and implementing*] **Develop and implement** alternative  
17 payment methodologies that are based on health care quality and improved  
18 health outcomes.

19 “(e) [*Coordinating*] **Coordinate** the delivery of physical health care,  
20 mental health and chemical dependency services, oral health care and cov-  
21 ered long-term care services.

22 “(f) [*Engaging*] **Engage** community members and health care providers in  
23 improving the health of the community and addressing regional, cultural,  
24 socioeconomic and racial disparities in health care that exist among the co-  
25 ordinated care organization’s members and in the coordinated care  
26 organization’s community.

27 “(2) In addition to the criteria **and requirements** specified in subsection  
28 (1) of this section, the authority must adopt by rule requirements for coor-  
29 dinated care organizations contracting with the authority so that:

30 “(a) Each member of the coordinated care organization receives integrated

1 person centered care and services designed to provide choice, independence  
2 and dignity.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

19       “(E) Include providers of specialty care.

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

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

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

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

1 provider networks.

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

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

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

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

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

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

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

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

16 “(E) At least one member of the community advisory council, **appointed**  
17 **by the council, who is a current or former member of a coordinated**  
18 **care organization.**

19 “(p) Each coordinated care organization’s governing body establishes  
20 standards for publicizing the activities of the coordinated care organization  
21 and the organization’s community advisory councils[, *as necessary,*] to keep  
22 the community informed. **The standards must include all requirements**  
23 **applicable to written minutes in ORS 192.650 and the minutes must be**  
24 **easily accessible on the coordinated care organization’s website.**

25 “(q) **The governing body of each coordinated care organization has**  
26 **a mechanism in place to ensure that activities of the governing body**  
27 **are regularly reported to the community advisory council of the co-**  
28 **ordinated care organization.**

29 “(r) **Each coordinated care organization makes publicly available**  
30 **the name and contact information for the chairperson of the govern-**

1 **ing body and either a member of the community advisory council or**  
2 **a designated employee of the coordinated care organization.**

3 **“(s) The governing body of each coordinated care organization holds**  
4 **at least one meeting jointly with its community advisory council each**  
5 **year that is open to the public.**

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

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

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

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

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

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

22 **“SECTION 2.** ORS 414.625, as amended by section 1 of this 2017 Act, is  
23 amended to read:

24 “414.625. (1) The Oregon Health Authority shall adopt by rule the quali-  
25 fication criteria and requirements for a coordinated care organization and  
26 shall integrate the criteria and requirements into each contract with a co-  
27 ordinated care organization. Coordinated care organizations may be local,  
28 community-based organizations or statewide organizations with community-  
29 based participation in governance or any combination of the two. Coordi-  
30 nated care organizations may contract with counties or with other public or

1 private entities to provide services to members. The authority may not con-  
2 tract with only one statewide organization. A coordinated care organization  
3 may be a single corporate structure or a network of providers organized  
4 through contractual relationships. **A coordinated care organization must**  
5 **be:**

6 **“(a) Recognized as tax exempt under section 501(c)(3) of the Internal**  
7 **Revenue Code of 1986; or**

8 **“(b) A public benefit corporation as defined in ORS 65.001.**

9 **“(2) The criteria and requirements adopted by the authority under sub-**  
10 **section (1) of this section must include, but are not limited to, a require-**  
11 **ment that the coordinated care organization:**

12 **“(a) Have demonstrated experience and a capacity for managing financial**  
13 **risk and establishing financial reserves.**

14 **“(b) Meet the following minimum financial requirements:**

15 **“(A) Maintain restricted reserves of \$250,000 plus an amount equal to 50**  
16 **percent of the coordinated care organization’s total actual or projected li-**  
17 **abilities above \$250,000.**

18 **“(B) Maintain a net worth in an amount equal to at least five percent of**  
19 **the average combined revenue in the prior two quarters of the participating**  
20 **health care entities.**

21 **“(C) Expend a portion of the annual net income or reserves of the coor-**  
22 **dinated care organization that exceed the financial requirements of this**  
23 **paragraph on services designed to address health disparities and the social**  
24 **determinants of health consistent with the coordinated care organization’s**  
25 **community health improvement plan and transformation plan and the terms**  
26 **and conditions of the Medicaid demonstration project under section 1115 of**  
27 **the Social Security Act (42 U.S.C. 1315).**

28 **“(c) Operate within a fixed global budget.**

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

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

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

9 “[2] (3) In addition to the criteria and requirements specified in sub-  
10 section [(1)] (2) of this section, the authority must adopt by rule require-  
11 ments for coordinated care organizations contracting with the authority so  
12 that:

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

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

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

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

26 “(e) Members receive assistance in navigating the health care delivery  
27 system and in accessing community and social support services and statewide  
28 resources, including through the use of certified health care interpreters, as  
29 defined in ORS 413.550, community health workers and personal health  
30 navigators who meet competency standards established by the authority un-



1 der ORS 414.665 or who are certified by the Home Care Commission under  
2 ORS 410.604.

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

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

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

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

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

20 “(k) Members have a choice of providers within the coordinated care  
21 organization’s network and that providers participating in a coordinated care  
22 organization:

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

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

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

30 “(D) Are permitted to participate in the networks of multiple coordinated

1 care organizations.

2 “(E) Include providers of specialty care.

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

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

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

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

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

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

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

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

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

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

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

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

29 “(E) At least one member of the community advisory council, appointed  
30 by the council, who is a current or former member of a coordinated care

1 organization.

2 “(p) Each coordinated care organization’s governing body establishes  
3 standards for publicizing the activities of the coordinated care organization  
4 and the organization’s community advisory councils to keep the community  
5 informed. The standards must include all requirements applicable to written  
6 minutes in ORS 192.650 and the minutes must be easily accessible on the  
7 coordinated care organization’s website.

8 “(q) The governing body of each coordinated care organization has a  
9 mechanism in place to ensure that activities of the governing body are reg-  
10 ularly reported to the community advisory council of the coordinated care  
11 organization.

12 “(r) Each coordinated care organization makes publicly available the  
13 name and contact information for the chairperson of the governing body and  
14 either a member of the community advisory council or a designated employee  
15 of the coordinated care organization.

16 “(s) The governing body of each coordinated care organization holds at  
17 least one meeting jointly with its community advisory council each year that  
18 is open to the public.

19 “[3] (4) The authority shall consider the participation of area agencies  
20 and other nonprofit agencies in the configuration of coordinated care or-  
21 ganizations.

22 “[4] (5) In selecting one or more coordinated care organizations to serve  
23 a geographic area, the authority shall:

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

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

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

1        “[5] (6) [On or before July 1, 2014,] Each coordinated care organization  
2 must have a formal contractual relationship with any dental care organiza-  
3 tion that serves members of the coordinated care organization in the area  
4 where they reside.

5        **“SECTION 3. In the adoption of rules to implement the amend-  
6 ments to ORS 414.625 (1)(b)(C) by section 1 of this 2017 Act, the Oregon  
7 Health Authority shall:**

8        **“(1) Convene a rules advisory committee under ORS 183.333 that  
9 includes one representative from each of the coordinated care organ-  
10 izations and other stakeholders;**

11        **“(2) Take into consideration:**

12        **“(a) The variability of coordinated care organizations’ operating  
13 budgets;**

14        **“(b) The obligations and investments of coordinated care organiza-  
15 tions;**

16        **“(c) The variability in risk-sharing arrangements between coordi-  
17 nated care organizations; and**

18        **“(d) The needed investments in infrastructure improvements that  
19 coordinated care organizations must make to ensure the long term  
20 viability of the coordinated care organizations’ ability to provide ser-  
21 vices; and**

22        **“(3) Consult with the Department of Consumer and Business Ser-  
23 vices with respect to financial requirements imposed on a coordinated  
24 care organization that is regulated by the department.**

25        **“SECTION 4. Section 5 of this 2017 Act is added to and made a part  
26 of ORS chapter 414.**

27        **“SECTION 5. (1) Coordinated care organizations shall report annu-  
28 ally to the Oregon Health Authority:**

29        **“(a) Financial information prescribed by the authority that dis-  
30 closes each coordinated care organization’s profit margin, medical and**

1 **nonmedical costs, investments and payments made to partner organ-**  
2 **izations; and**

3 **“(b) The activities of the governing body and the community advi-**  
4 **sory council for each coordinated care organization.**

5 **“(2) The authority shall publish the information reported under this**  
6 **section on the authority’s website.”.**

7 In line 17, delete “5” and insert “6”.

8 On page 5, line 21, delete “6” and insert “7”.

9 On page 8, after line 39, insert:

10 “(25) ‘Transformation plan’ means the terms in a contract between the  
11 authority and a coordinated care organization that specify the benchmarks  
12 that the coordinated care organization must meet in order to comply with  
13 the provisions of ORS 414.625.

14 **“SECTION 8.** ORS 414.653 is amended to read:

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

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

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

21 “(c) Reward good performance;

22 “(d) Limit increases in medical costs; and

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

24 “(A) Promote prevention;

25 “(B) Provide person centered care; and

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

28 “(2) The authority shall [*encourage*] **work with each** coordinated care  
29 [*organizations to utilize*] **organization to develop individual plans to**  
30 **move each coordinated care organization toward greater utilization of**

1 alternative payment methodologies [*that move from a predominantly fee-for-*  
2 *service system to payment methods*] that base reimbursement on the quality  
3 rather than the quantity of services provided. **Each plan must:**

4 **“(a) Describe how coordinated care organizations and contracted**  
5 **providers will, by December 31, 2023, meet benchmarks established by**  
6 **the authority in the use of alternative payment methodologies to re-**  
7 **imburse providers;**

8 **“(b) Provide a broad definition of alternative payment methodol-**  
9 **ogies that aligns with the payment models developed by the Center for**  
10 **Medicaid and Medicare Innovation; and**

11 **“(c) Allow a coordinated care organization to phase in the use of**  
12 **alternative payment methodologies over the term of the coordinated**  
13 **care organization’s contract with the authority.**

14 “(3) The authority shall assist and support coordinated care organizations  
15 in identifying cost-cutting measures.

16 “(4) If a service provided in a health care facility is not covered by  
17 Medicare because the service is related to a health care acquired condition,  
18 the cost of the service may not be:

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

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

23 “(5)(a) Notwithstanding subsections (1) and (2) of this section, until July  
24 1, 2014, a coordinated care organization that contracts with a Type A or Type  
25 B hospital or a rural critical access hospital, as described in ORS 442.470,  
26 shall reimburse the hospital fully for the cost of covered services based on  
27 the cost-to-charge ratio used for each hospital in setting the global payments  
28 to the coordinated care organization for the contract period.

29 “(b) The authority shall base the global payments to coordinated care  
30 organizations that contract with rural hospitals described in this section on

1 the most recent audited Medicare cost report for Oregon hospitals adjusted  
2 to reflect the Medicaid mix of services.

3 “(c) The authority shall identify any rural hospital that would not be  
4 expected to remain financially viable if paid in a manner other than as pre-  
5 scribed in paragraphs (a) and (b) of this subsection based upon an evaluation  
6 by an actuary retained by the authority. On and after July 1, 2014, the au-  
7 thority may, on a case-by-case basis, require a coordinated care organization  
8 to continue to reimburse a rural hospital determined to be at financial risk,  
9 in the manner prescribed in paragraphs (a) and (b) of this subsection.

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

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

15 “(6) Notwithstanding subsections (1) and (2) of this section, coordinated  
16 care organizations must comply with federal requirements for payments to  
17 providers of Indian health services, including but not limited to the re-  
18 quirements of 42 U.S.C. 1396j and 42 U.S.C. 1396u-2(a)(2)(C).

19 **“SECTION 9.** ORS 414.653, as amended by section 8 of this 2017 Act, is  
20 amended to read:

21 “414.653. (1) The Oregon Health Authority shall encourage coordinated  
22 care organizations to use alternative payment methodologies that:

23 “(a) Reimburse providers on the basis of health outcomes and quality  
24 measures instead of the volume of care;

25 “(b) Hold organizations and providers responsible for the efficient deliv-  
26 ery of quality care;

27 “(c) Reward good performance;

28 “(d) Limit increases in medical costs; and

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

30 “(A) Promote prevention;

1 “(B) Provide person centered care; and

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

4 “[*(2) The authority shall work with each coordinated care organization to*  
5 *develop individual plans to move each coordinated care organization toward*  
6 *greater utilization of alternative payment methodologies that base reimburse-*  
7 *ment on the quality rather than the quantity of services provided. Each plan*  
8 *must:]*

9 “[*(a) Describe how coordinated care organizations and contracted providers*  
10 *will, by December 31, 2023, meet benchmarks established by the authority in*  
11 *the use of alternative payment methodologies to reimburse providers;]*

12 “[*(b) Provide a broad definition of alternative payment methodologies that*  
13 *aligns with the payment models developed by the Center for Medicaid and*  
14 *Medicare Innovation; and]*

15 “[*(c) Allow a coordinated care organization to phase in the use of alterna-*  
16 *tive payment methodologies over the term of the coordinated care organization’s*  
17 *contract with the authority.]*

18 “[*(3)*] **(2)** The authority shall assist and support coordinated care organ-  
19 izations in identifying cost-cutting measures.

20 “[*(4)*] **(3)** If a service provided in a health care facility is not covered by  
21 Medicare because the service is related to a health care acquired condition,  
22 the cost of the service may not be:

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

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

27 “[*(5)(a)*] **(4)(a)** Notwithstanding [*subsections (1) and (2)*] **subsection (1)**  
28 of this section, until July 1, 2014, a coordinated care organization that con-  
29 tracts with a Type A or Type B hospital or a rural critical access hospital,  
30 as described in ORS 442.470, shall reimburse the hospital fully for the cost



1 of covered services based on the cost-to-charge ratio used for each hospital  
2 in setting the global payments to the coordinated care organization for the  
3 contract period.

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

8 “(c) The authority shall identify any rural hospital that would not be  
9 expected to remain financially viable if paid in a manner other than as pre-  
10 scribed in paragraphs (a) and (b) of this subsection based upon an evaluation  
11 by an actuary retained by the authority. On and after July 1, 2014, the au-  
12 thority may, on a case-by-case basis, require a coordinated care organization  
13 to continue to reimburse a rural hospital determined to be at financial risk,  
14 in the manner prescribed in paragraphs (a) and (b) of this subsection.

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

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

20 “[~~(6)~~] **(5)** Notwithstanding [*subsections (1) and (2)*] **subsection (1)** of this  
21 section, coordinated care organizations must comply with federal require-  
22 ments for payments to providers of Indian health services, including but not  
23 limited to the requirements of 42 U.S.C. 1396j and 42 U.S.C.  
24 1396u-2(a)(2)(C).”.

25 Delete lines 40 and 41 and insert:

26 “**SECTION 10.** The amendments to ORS 414.025, 414.625, 414.627 and  
27 414.653 by sections 1 and 6 to 8 of this 2017 Act apply.”.

28 On page 9, after line 1, insert:

29 “**SECTION 11. (1) The amendments to ORS 414.625 by section 2 of**  
30 **this 2017 Act become operative on January 1, 2023.**”

1       **“(2) The amendments to ORS 414.653 by section 9 of this 2017 Act**  
2 **become operative on January 1, 2024.**

3       **“SECTION 12. Section 3 of this 2017 Act is repealed on December**  
4 **31, 2019.”.**

5       In line 2, delete “8” and insert “13”.

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