LC 194
2026 Regular Session
1/8/26 (RH/ps)

D R A F T

SUMMARY

Digest: The Act requires OHA to change the way it sets rates for CCOs. The Act adds steps that OHA must take before making new rules. The Act prevents OHA from taking certain costly measures until January 2, 2028. (Flesch Readability Score: 69.3).

Requires the Oregon Health Authority to develop a transparent and data-driven process for developing capitation rates for coordinated care organizations. Requires the Oregon Health Policy Board to establish a process for public review of and comment on the authority's rate development process. Requires the authority to commission an independent review of the current rate development process and report back to the Legislative Assembly.

Requires the authority to prepare a medical assistance cost impact statement before adopting rules other than procedural rules.

Prohibits the authority from adopting a new rule, program or contractual requirement that will cost $1 million or more during a biennium. Sunsets on January 2, 2028.

Imposes a three-year moratorium on the requirement for a coordinated care organization to spend a portion of the organization's annual net income or reserves on addressing health disparities and the social determinants of health.

Declares an emergency, effective on passage.

A BILL FOR AN ACT

Relating to medical assistance; creating new provisions; amending ORS 413.011, 413.042, 414.065, 414.572 and 414.590 and section 2, chapter 467, Oregon Laws 2021; and declaring an emergency.

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

SECTION 1. Section 2 of this 2026 Act is added to and made a part of ORS chapter 414.

SECTION 2. (1) As used in this section:

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.

(a) "Base data" means the eligibility, enrollment, encounter and other data used by the Oregon Health Authority to develop capitation rates for the following year.

(b) "Capitation rate" means a fixed dollar amount paid per member per month by the authority to a coordinated care organization for the provision of medical assistance to members of the coordinated care organization.

(c) "Medical loss ratio" means the proportion of a coordinated care organization's global budget that is spent on health care services, quality improvement and fraud prevention activities, as prescribed by the authority by rule consistent with federal law.

(2) The authority shall establish a transparent and data-driven process for developing capitation rates. As part of the rate development process, the authority shall:

(a) Reconcile the authority's base data with data submitted by coordinated care organizations and identify any adjustments that the authority makes to the base data.

(b) Identify the cost impact of any changes in a proposed contract or annual contract restatement and include that information in the preliminary rate publication required under paragraph (g) of this subsection. In analyzing the cost impact of contract changes, the authority shall separately identify the cost of the previous year's contractual requirements and the cost of the new requirements in the proposed contract or contract restatement.

(c) Identify any efficiencies or cost savings in a separate analysis.

(d) Use only non-proprietary, transparent algorithms or similar methods to identify savings or cost reduction opportunities. Any algorithm or similar method used by the authority must be independently verifiable by an actuary retained by a coordinated care organization.

(e) Provide to each coordinated care organization a list of any

outlier trends that appear to be affecting statewide average data.

(f) Provide to interested parties 90 days' notice of changes to the authority's schedule of fee-for-service reimbursement rates and make appropriate adjustments to the capitation rates developed under this section.

(g) Publish the authority's preliminary capitation rate determinations for review and comment by coordinated care organizations, consistent with the review process established by the Oregon Health Policy Board under ORS 413.011.

(3) In applying any minimum medical loss ratio requirements for coordinated care organizations, the authority shall calculate the medical loss ratio as a three-year rolling average.

SECTION 3. Section 2 of this 2026 Act applies to plan years beginning on or after January 1, 2027.

SECTION 4. ORS 414.065 is amended to read:

414.065. (1)(a) Consistent with ORS 414.690, 414.710, 414.712 and**,** 414.766 **and section 2 of this 2026 Act** 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 **pursuant to section 2 of this 2026 Act**:

(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 consider the community health assessment conducted by the organization in accordance with ORS 414.577 and reviewed annually, and the organization's health care costs; and

(c) The authority shall take into account the organization's provision of innovative, nontraditional health services.

(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 5. ORS 413.011 is amended to read:

413.011. (1) The duties of the Oregon Health Policy Board are to:

(a) Be the policy-making and oversight body for the Oregon Health Authority established in ORS 413.032 and all of the authority's departmental divisions.

(b) Develop and submit a plan to the Legislative Assembly to provide and fund access to affordable, quality health care for all Oregonians.

(c) Develop a program to provide health insurance premium assistance to all low and moderate income individuals who are legal residents of Oregon.

(d) Publish health outcome and quality measure data collected by the Oregon Health Authority at aggregate levels that do not disclose information otherwise protected by law. The information published must report, for each coordinated care organization and each health benefit plan sold through the health insurance exchange or offered by the Oregon Educators Benefit Board or the Public Employees' Benefit Board:

(A) Quality measures;

(B) Costs;

(C) Health outcomes; and

(D) Other information that is necessary for members of the public to evaluate the value of health services delivered by each coordinated care organization and by each health benefit plan.

(e) Establish evidence-based clinical standards and practice guidelines that may be used by providers.

(f) Approve and monitor community-centered health initiatives described in ORS 413.032 (1)(h) that are consistent with public health goals, strategies, programs and performance standards adopted by the Oregon Health Policy Board to improve the health of all Oregonians, and to regularly report to the Legislative Assembly on the accomplishments and needed changes to the initiatives.

(g) Establish cost containment mechanisms to reduce health care costs.

(h) Ensure that Oregon's health care workforce is sufficient in numbers and training to meet the demand that will be created by the expansion in health coverage, health care system transformations, an increasingly diverse population and an aging workforce.

(i) Work with the Oregon congressional delegation to advance the adoption of changes in federal law or policy to promote Oregon's comprehensive health reform plan.

(j) Establish a health benefit package in accordance with ORS 741.340 to be used as the baseline for all health benefit plans offered through the health insurance exchange.

(k) Investigate and report annually to the Legislative Assembly on the feasibility and advisability of future changes to the health insurance market in Oregon, including but not limited to the following:

(A) A requirement for every resident to have health insurance coverage.

(B) A payroll tax as a means to encourage employers to continue providing health insurance to their employees.

(L) Meet cost-containment goals by structuring reimbursement rates to reward comprehensive management of diseases, quality outcomes and the efficient use of resources by promoting cost-effective procedures, services and programs including, without limitation, preventive health, dental and primary care services, web-based office visits, telephone consultations and telemedicine consultations.

(m) Oversee the expenditure of moneys from the Health Care Provider Incentive Fund to support grants to primary care providers and rural health

practitioners, to increase the number of primary care educators and to support efforts to create and develop career ladder opportunities.

(n) Work with the Public Health Benefit Purchasers Committee, administrators of the medical assistance program and the Department of Corrections to identify uniform contracting standards for health benefit plans that achieve maximum quality and cost outcomes and align the contracting standards for all state programs to the greatest extent practicable.

(o) Work with the Health Information Technology Oversight Council to foster health information technology systems and practices that promote the Oregon Integrated and Coordinated Health Care Delivery System established by ORS 414.570 and align health information technology systems and practices across this state.

(p) Establish a review process by which the public may comment on the authority's rate development process for capitation rates under section 2 of this 2026 Act and fee-for-service reimbursement rates and a process for reviewing and approving:

(A) The methods for the public to provide input on rate methodologies;

(B) The methods for interested parties to provide input on capitation rates before the authority finalizes a capitation rate certification for submission to the Centers for Medicare and Medicaid Services; and

(C) Public-facing materials and communication strategies for engaging interested parties.

(2) The Oregon Health Policy Board is authorized to:

(a) Subject to the approval of the Governor, organize and reorganize the authority as the board considers necessary to properly conduct the work of the authority.

(b) Submit directly to the Legislative Counsel, no later than October 1 of each even-numbered year, requests for measures necessary to provide statutory authorization to carry out any of the board's duties or to imple-

ment any of the board's recommendations. The measures may be filed prior to the beginning of the legislative session in accordance with the rules of the House of Representatives and the Senate.

(3) If the board or the authority is unable to perform, in whole or in part, any of the duties described in ORS 413.006 to 413.042 and 741.340 without federal approval, the authority is authorized to request, in accordance with ORS 413.072, waivers or other approval necessary to perform those duties. The authority shall implement any portions of those duties not requiring legislative authority or federal approval, to the extent practicable.

(4) The enumeration of duties, functions and powers in this section is not intended to be exclusive nor to limit the duties, functions and powers imposed on the board by ORS 413.006 to 413.042 and 741.340 and by other statutes.

(5) The board shall consult with the Department of Consumer and Business Services in completing the tasks set forth in subsection (1)(j) and (k)(A) of this section.

SECTION 6. ORS 414.590 is amended to read:

414.590. (1) As used in this section:

(a) "Benefit period" means a period of time, shorter than the contract term, for which specific terms and conditions in a contract between a coordinated care organization and the Oregon Health Authority are in effect.

(b) "Renew" means an agreement by a coordinated care organization to amend the terms or conditions of an existing contract for the next benefit period.

(2) A contract entered into between the authority and a coordinated care organization under ORS 414.572 (1):

(a) Shall be:

(A) For an initial term of no less than five years; and

(B) The same length for all coordinated care organizations contracting with the authority;

(b) Except as provided in subsection (4) of this section, may not be

amended more than once in each 12-month period; and

(c) May be terminated by the authority if a coordinated care organization fails to meet outcome and quality measures specified in the contract or is otherwise in breach of the contract.

(3) This section does not prohibit the authority from allowing a coordinated care organization a reasonable amount of time in which to cure any failure to meet outcome and quality measures specified in the contract prior to the termination of the contract.

(4) A contract entered into between the authority and a coordinated care organization may be amended:

(a) More than once in each 12-month period if:

(A) The authority and the coordinated care organization mutually agree to amend the contract; or

(B) Amendments are necessitated by changes in federal or state law.

(b) Once within the first eight months of the effective date of the contract if needed to adjust the global budget of a coordinated care organization, retroactive to the beginning of the calendar year, to take into account changes in the membership of the coordinated care organization or the health status of the coordinated care organization's members.

(5) Except as provided in subsection (8) of this section, the authority must give a coordinated care organization at least 60 days' advance notice of any amendments the authority proposes to existing contracts between the authority and the coordinated care organization.

(6) Except as provided in subsection (4)(b) of this section, an amendment to a contract may apply retroactively only if:

(a) The amendment does not result in a claim by the authority for the recovery of amounts paid by the authority to the coordinated care organization prior to the date of the amendment; or

(b) The Centers for Medicare and Medicaid Services notifies the authority, in writing, that the amendment is a condition for approval of the contract by the Centers for Medicare and Medicaid Services.

(7) If an amendment to a contract under subsection (6)(b) of this section or other circumstances arise that result in a claim by the authority for the recovery of amounts previously paid to a coordinated care organization by the authority, the authority shall ensure that the recovery does not have a material adverse effect on the coordinated care organization's ability to maintain the required minimum amounts of risk-based capital.

(8) No later than 134 days prior to the end of a benefit period, the authority shall provide to each coordinated care organization notice of the proposed changes to the terms and conditions of a contract, as will be submitted to the Centers for Medicare and Medicaid Services for approval, for the next benefit period.

(9) A coordinated care organization must notify the authority of the coordinated care organization's refusal to renew a contract with the authority no later than [*14*] **30** days after the authority provides the notice described in subsection (8) of this section. Except as provided in subsections (10) and (11) of this section, a refusal to renew terminates the contract at the end of the benefit period.

(10) The authority may require a contract to remain in force into the next benefit period and be amended as proposed by the authority until 90 days after the coordinated care organization has, in accordance with criteria prescribed by the authority:

(a) Notified each of its members and contracted providers of the termination of the contract;

(b) Provided to the authority a plan to transition its members to another coordinated care organization; and

(c) Provided to the authority a plan for closing out its coordinated care organization business.

(11) The authority may waive compliance with the deadlines in subsections (9) and (10) of this section if the Director of the Oregon Health Authority finds that the waiver of the deadlines is consistent with the effective and efficient administration of the medical assistance program and

the protection of medical assistance recipients.

SECTION 7. (1) As used in this section, "capitation rate" has the meaning given that term in section 2 of this 2026 Act.

(2) The Oregon Health Authority shall commission an independent review and analysis of the authority's process for developing capitation rates. The review shall identify:

(a) Opportunities for increased transparency and efficiency; and

(b) Ways to avoid duplication of efforts and unnecessary administrative burdens.

(3) The authority shall submit a report in the manner provided by ORS 192.245, and may include recommendations for legislation, to the interim committees of the Legislative Assembly related to health no later than September 15, 2027.

SECTION 8. Section 7 of this 2026 Act is repealed on January 2, 2028.

SECTION 9. ORS 413.042 is amended to read:

413.042. **(1)** In accordance with applicable provisions of ORS chapter 183, the Director of the Oregon Health Authority may adopt rules necessary for the administration of the laws that the Oregon Health Authority is charged with administering.

(2) Before adopting any permanent or temporary rule, except a procedural rule, the authority shall prepare a medical assistance cost impact statement that estimates the economic impact of the adoption of the rule on the state medical assistance program. The authority shall adopt the form of the statement.

SECTION 10. Section 11 of this 2026 Act is added to and made a part of ORS chapter 414.

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

(a) "Health care entity" means a coordinated care organization or a provider that is compensated on a prepaid capitated basis for providing health services to medical assistance recipients.

(b) "Major initiative" means a new rule, program or contractual

requirement that will cost the Oregon Health Authority or health care entities $1 million or more during a biennium.

(2) The authority may not adopt a major initiative unless required by state or federal law.

SECTION 12. Section 11 of this 2026 Act is repealed, on January 2, 2028.

SECTION 13. ORS 414.572 is amended to read:

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

(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 coordi-*

nated 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 defined 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 subcontractor 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)(a) The authority shall:

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

(B) Incorporate the requirements adopted under this subsection into any contract entered into between the authority and a coordinated care organization under this section.

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

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

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

(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 14. ORS 414.572, as amended by section 13 of this 2026 Act, is amended to read:

414.572. (1) The Oregon Health Authority shall adopt by rule the qualification criteria and requirements for a coordinated care organization and shall integrate the criteria and requirements into each contract with a coordinated care organization. Coordinated care organizations may be local, community-based organizations or statewide organizations with community-based participation in governance or any combination of the two. Coordinated care organizations may contract with counties or with other public or private entities to provide services to members. The authority may not contract with only one statewide organization. A coordinated care organization may be a single corporate structure or a network of providers organized

through contractual relationships. The criteria and requirements adopted by the authority under this section must include, but are not limited to, a requirement that the coordinated care organization:

(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 defined 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 subcontractor 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)(a) The authority shall:

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

(B) Incorporate the requirements adopted under this subsection into any contract entered into between the authority and a coordinated care organization under this section.

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

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

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

(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 15. The amendments to ORS 414.572 by section 14 of this 2026 Act become operative on January 1, 2030.

SECTION 16. Section 2, chapter 467, Oregon Laws 2021, is amended to read:

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

(2) The authority shall seek approval from the Centers for Medicare and Medicaid Services to:

(a) Require a coordinated care organization to spend up to three percent of its global budget on investments:

(A)(i) In programs or services that improve health equity by addressing the preventable differences in the burden of disease, injury or violence or in opportunities to achieve optimal health that are experienced by socially disadvantaged populations;

(ii) In community-based programs addressing the social determinants of health;

(iii) In efforts to diversify care locations; or

(iv) In programs or services that improve the overall health of the community; or

(B) That enhance payments to:

(i) Providers who address the need for culturally and linguistically appropriate services in their communities;

(ii) Providers who can demonstrate that increased funding will improve health services provided to the community as a whole; or

(iii) Support staff based in the community that aid all underserved populations, including but not limited to peer-to-peer support staff with cultural backgrounds, health system navigators in nonmedical settings and public

guardians.

(b) Require a coordinated care organization to spend at least 30 percent of the funds described in paragraph (a) of this subsection on programs or efforts to achieve health equity for racial, cultural or traditionally underserved populations in the communities served by the coordinated care organization.

(c) Require a coordinated care organization to spend at least 20 percent of the funds described in paragraph (a) of this subsection on efforts to:

(A) Improve the behavioral health of members;

(B) Improve the behavioral health care delivery system in the community served by the coordinated care organization;

(C) Create a culturally and linguistically competent health care workforce; or

(D) Improve the behavioral health of the community as a whole.

(3) Expenditures described in subsection (2) of this section are in addition to [*the expenditures required by ORS 414.572 (1)(b)(C)*] **any other expenditures that a coordinated care organization is required by law to make to address health disparities or the social determinants of health** and must:

(a) Be part of a plan developed in collaboration with or directed by members of organizations or organizations that serve local priority populations that are underserved in communities served by the coordinated care organization, including but not limited to regional health equity coalitions, and be approved by the coordinated care organization's community advisory council;

(b) Demonstrate, through practice-based or community-based evidence, improved health outcomes for individual members of the coordinated care organization or the overall community served by the coordinated care organization;

(c) Be expended from a coordinated care organization's global budget with the least amount of state funding; and

(d) Be counted as medical expenses by the authority in a coordinated care organization's base medical budget when calculating the coordinated care organization's global budget and flexible spending requirements for a given year.

(4) Expenditures by a coordinated care organization in working with one or more of the nine federally recognized tribes in this state or urban Indian health programs to achieve health equity may qualify as expenditures under subsection (2) of this section.

(5) The authority shall:

(a) Make publicly available the outcomes described in subsection (3)(b) of this section; and

(b) Report expenditures under subsection (2) of this section to the Centers for Medicare and Medicaid Services.

(6) Upon receipt of approval from the Centers for Medicare and Medicaid Services to carry out the provisions of this section, the authority shall adopt rules in accordance with the terms of the approval.

SECTION 17. Section 2, chapter 467, Oregon Laws 2021, as amended by section 3, chapter 467, Oregon Laws 2021, is amended to read:

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

(2) The authority shall:

(a) Require a coordinated care organization to spend no less than three percent of its global budget on investments:

(A)(i) In programs or services that improve health equity by addressing the preventable differences in the burden of disease, injury or violence or in opportunities to achieve optimal health that are experienced by socially disadvantaged populations;

(ii) In community-based programs addressing the social determinants of health;

(iii) In efforts to diversify care locations; or

(iv) In programs or services that improve the overall health of the community; or

(B) That enhance payments to:

(i) Providers who address the need for culturally and linguistically appropriate services in their communities;

(ii) Providers who can demonstrate that increased funding will improve health services provided to the community as a whole; or

(iii) Support staff based in the community that aid all underserved populations, including but not limited to peer-to-peer support staff with cultural backgrounds, health system navigators in nonmedical settings and public guardians.

(b) Require a coordinated care organization to spend at least 30 percent of the funds described in paragraph (a) of this subsection on programs or efforts to achieve health equity for racial, cultural or traditionally underserved populations in the communities served by the coordinated care organization.

(c) Require a coordinated care organization to spend at least 20 percent of the funds described in paragraph (a) of this subsection on efforts to:

(A) Improve the behavioral health of members;

(B) Improve the behavioral health care delivery system in the community served by the coordinated care organization;

(C) Create a culturally and linguistically competent health care workforce; or

(D) Improve the behavioral health of the community as a whole.

(3) Expenditures described in subsection (2) of this section are in addition to [*the expenditures required by ORS 414.572 (1)(b)(C)*] **any other expenditures that a coordinated care organization is required by law to make to address health disparities or the social determinants of health** and must:

(a) Be part of a plan developed in collaboration with or directed by members of organizations or organizations that serve local priority popu-

lations that are underserved in communities served by the coordinated care organization, including but not limited to regional health equity coalitions, and be approved by the coordinated care organization's community advisory council;

(b) Demonstrate, through practice-based or community-based evidence, improved health outcomes for individual members of the coordinated care organization or the overall community served by the coordinated care organization;

(c) Be expended from a coordinated care organization's global budget with the least amount of state funding; and

(d) Be counted as medical expenses by the authority in a coordinated care organization's base medical budget when calculating the coordinated care organization's global budget and flexible spending requirements for a given year.

(4) Expenditures by a coordinated care organization in working with one or more of the nine federally recognized tribes in this state or urban Indian health programs to achieve health equity may qualify as expenditures under subsection (2) of this section.

(5) The authority shall:

(a) Make publicly available the outcomes described in subsection (3)(b) of this section; and

(b) Report expenditures under subsection (2) of this section to the Centers for Medicare and Medicaid Services.

(6) The authority shall convene an oversight committee in consultation with the office within the authority that is charged with ensuring equity and inclusion. The oversight committee shall be composed of members who represent the regional and demographic diversity of this state based on statistical evidence compiled by the authority about medical assistance recipients and at least one representative from the nine federally recognized tribes in this state or urban Indian health programs. The oversight committee shall:

(a) Evaluate the impact of expenditures described in subsection (2) of this

section on promoting health equity and improving the social determinants of health in the communities served by each coordinated care organization;

(b) Recommend best practices and criteria for investments described in subsection (2) of this section; and

(c) Resolve any disputes between the authority and a coordinated care organization over what qualifies as an expenditure under subsection (2) of this section.

SECTION 18. This 2026 Act being necessary for the immediate preservation of the public peace, health and safety, an emergency is declared to exist, and this 2026 Act takes effect on its passage.
