House Bill 2205

Introduced and printed pursuant to House Rule 12.00. Presession filed (at the request of House Interim Committee on Behavioral Health and Health Care for Representative Rob Nosse)

SUMMARY

The following summary is not prepared by the sponsors of the measure and is not a part of the body thereof subject to consideration by the Legislative Assembly. It is an editor's brief statement of the essential features of the measure **as introduced.** The statement includes a measure digest written in compliance with applicable readability standards.

Digest: The Act changes the contract term to 10 years for contracts between OHA and CCOs. (Flesch Readability Score: 73.1).

Extends the term of a contract entered into between the Oregon Health Authority and a coordinated care organization to 10 years. Directs the authority to review a coordinated care organization's performance after the initial five years of a contract term.

A BILL FOR AN ACT

Relating to coordinated care organization contracts; creating new provisions; and amending ORS 414.590.

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

SECTION 1. 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 five-year 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 for a term of [*five*] **10** years;

(b) Except as provided in subsection [*(4)*] **(5)** 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) After the initial five years of a contract entered into between the authority and a coordinated care organization under subsection (2)(a) of this section, the authority shall review the coordinated care organization's performance in a manner prescribed by the authority by rule, including a review of:

(a) The coordinated care organization's performance on quality measures for the preceding five years;

(b) The coordinated care organization's performance on external quality reviews under ORS 414.595 for the preceding five years; and

(c) The extent to which the coordinated care organization's community advisory council has been afforded the opportunity for meaningful participation.

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.

[*(3)*] **(4)** 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)*] **(5)** 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)*] **(6)** Except as provided in subsection [*(8)*] **(9)** 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)*] **(7)** Except as provided in subsection [*(4)(b)*] **(5)(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)*] **(8)** If an amendment to a contract under subsection [*(6)(b)*] **(7)(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)*] **(9)** 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)*] **(10)** 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 days after the authority provides the notice described in subsection [*(8)*] **(9)** of this section. Except as provided in subsections [*(10)*] **(11)** and [*(11)*] **(12)** of this section, a refusal to renew terminates the contract at the end of the benefit period.

[*(10)*] **(11)** 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)*] **(12)** The authority may waive compliance with the deadlines in subsections [*(9)*] **(10)** and

[*(10)*] **(11)** 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 2. The amendments to ORS 414.590 by section 1 of this 2025 Act apply to contracts between a coordinated care organization and the Oregon Health Authority entered into, amended or renewed on or after the effective date of this 2025 Act.