House Bill 2229

Sponsored by Representative NOSSE (Presession filed.)

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 makes changes to the CCO procurement process. (Flesch Readability Score: 66.1).

Extends the term of a contract entered into between the Oregon Health Authority and a coordinated care organization to 10 years and allows the authority to reevaluate a contract after the initial five years. Imposes new restrictions on the authority's ability to amend coordinated care organization contracts. Directs the authority to develop standards for evaluating applications for and awarding new contracts to coordinated care organizations. Requires that certain conditions be met before a new or existing coordinated care organization may serve an area that is already served by one or more coordinated care organizations.

Declares an emergency, effective on passage.

A BILL FOR AN ACT

Relating to coordinated care organizations; creating new provisions; amending ORS 414.590; and declaring an emergency.

Whereas Oregonians will benefit from clarity, fairness and transparency in the contract procurement process for coordinated care organizations; and

Whereas stakeholders in the coordinated care organization model place a premium on prior contractual performance by existing coordinated care organizations and value existing local relationships; and

Whereas adding additional coordinated care organizations to areas already served by existing coordinated care organizations can disrupt the continuity of care for members; now, therefore,

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

COORDINATED CARE ORGANIZATION CONTRACTS

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*] **10-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) "Good standing" means the status of a coordinated care organization if:

(A) The coordinated care organization has met the minimum financial requirements under ORS 414.572 (1)(b);

(B) The coordinated care organization has not materially breached its contract with the authority under this section; and

(C) The authority has not determined that the health or welfare of the members of the coordinated care organization is in jeopardy.

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.

[*(b)*] **(c)** "Renew" means [*an agreement by a coordinated care organization to amend the terms or conditions of an existing contract for the next benefit period*] **an agreement between a coordinated care organization and the authority to enter into a contract for a new 10-year term**.

(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 **or not renewed** 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.*]**:**

(A) If the authority determines that the health or welfare of the members of the coordinated care organization is in jeopardy;

(B) If, within the current term of the contract and for reasons within the control of the coordinated care organization, the coordinated care organization:

(i) Fails to meet outcome and quality measures specified in the contract;

(ii) Fails to meet the minimum financial requirements under ORS 414.572 (1)(b); or

(iii) Is in material breach of the contract; or

(C) As provided in subsection (4) of this section.

[*(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.*]

(3)(a) No later than 15 months before the expiration of a contract entered into between the authority and a coordinated care organization, the authority and the coordinated care organization shall provide notice, in the form and manner prescribed by the authority, of the intent of the authority or the coordinated care organization to renew or not renew the contract.

(b) If the authority provides notice of intent not to renew a contract under this subsection, the authority shall provide:

(A) Written notice, at least six months before the expiration of the contract term, of the reasons for the decision;

(B) A reasonable amount of time for the coordinated care organization to cure any failure to meet outcome and quality measures specified in the contract; and

(C) An opportunity for a contested case hearing under ORS chapter 183.

(4)(a) After the initial five years of a contract term, the authority may reevaluate a contract entered into between the authority and a coordinated care organization if the coordinated care organization is not in good standing.

(b) As part of a reevaluation under this subsection, the authority shall develop a corrective action plan that provides the coordinated care organization at least six months to cure the reason that the coordinated care organization is not in good standing;

(c) If a coordinated care organization fails to cure the reason that the coordinated care organization is not in good standing, the authority may:

(A) Modify the coordinated care organization's service area if another coordinated care organization has requested entry into the service area and a service area entry assessment has been conducted in accordance with section 4 of this 2025 Act; or

(B) Terminate the contract between the authority and the coordinated care organization and provide the coordinated care organization written notice of the reasons for the termination.

[*(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) 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) The process for amending contracts under this section must be transparent and must include:

(a) An analysis of the impact of the amendments on the Oregon Integrated and Coordinated Health Care Delivery System established by ORS 414.570;

(b) Except as provided in subsection (10) of this section, 45 days' notice to a coordinated care organization and the opportunity for the coordinated care organization to comment on the proposed changes; and

(c) The date on which the proposed changes are scheduled to take effect.

(7) The authority shall issue the final draft of any guidance on a proposed change to the terms and conditions of a contract entered into between the authority and a coordinated care organization no less than 60 days before the date on which the proposed change takes effect.

[*(6)*] **(8)** 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)*] **(9)** If an amendment to a contract under subsection [*(6)(b)*] **(8)(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)*] **(10)** 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)*] **(11)** A coordinated care organization must notify the authority of the coordinated care organization's refusal to [*renew*] **amend** a contract with the authority **to include the changes**

proposed under subsection (10) of this section no later than 14 days after the authority provides the notice described in subsection [*(8)*] **(10)** of this section. Except as provided in subsections [*(10)*] **(12)** and [*(11)*] **(13)** of this section, a refusal to [*renew*] **amend** terminates the contract at the end of the benefit period.

[*(10)*] **(12)** 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)*] **(13)** The authority may waive compliance with the deadlines in subsections [*(9)*] **(11)** and [*(10)*] **(12)** 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. Sections 3 and 4 of this 2025 Act are added to and made a part of ORS chapter 414.

SECTION 3. (1) The Oregon Health Authority shall develop standards for evaluating applications for and awarding new contracts to coordinated care organizations under ORS 414.590. The standards must include consideration of:

(a) Whether any existing coordinated care organization in a service area is in good standing, as defined in ORS 414.590;

(b) The performance during the most recent contract term of any existing coordinated care organization in a service area;

(c) The impact on the continuity of care for members of any existing coordinated care organization in a service area;

(d) The relationship between the local community and any existing coordinated care organization in a service area; and

(e) The past and ongoing investments made in the local community by any existing coordinated care organization in a service area.

(2) In developing the standards under this section, the authority shall:

(a) Ensure that all coordinated care organizations are afforded a meaningful opportunity to participate; and

(b) Incorporate feedback from:

(A) Each coordinated care organization's community advisory council; and

(B) Members of each coordinated care organization.

(3) At least 90 days before evaluating applications for new contracts, the authority shall provide the final draft of the standards developed under this section to each existing coordinated care organization and post the final draft of the standards on the authority's website.

SERVICE AREA CHANGE

SECTION 4. (1) The Oregon Health Authority may not allow a new or existing coordinated care organization to begin serving an area that is already served by one or more coordinated care organizations, unless:

(a) The coordinated care organizations serving the area have failed to meet quality measures relating to access to care for at least five of the last 20 quarters; or

(b) The authority determines that adding another coordinated care organization to an existing service area is in the best interest of the service area's members and issues a written report explaining the reasons for the determination.

(2) If one of the conditions under subsection (1) of this section is met, the authority shall conduct a service area entry assessment to determine whether to allow a new or existing coordinated care organization to begin serving the area. The service area entry assessment must:

(a) Be a public process;

(b) Be initiated at least 280 days before a new or existing coordinated care organization is allowed to begin serving an area that is already served by one or more coordinated care organizations; and

(c) Include input from the coordinated care organizations serving the area and their community advisory councils.

(3) In conducting a service area entry assessment under this section, the authority shall consider whether:

(a) The service area includes more than 50,000 members;

(b) The coordinated care organizations serving the area are in good standing, as defined in ORS 414.590; and

(c) Members in the service area are likely to work or receive care in an adjoining region.

(4) The authority shall collect from coordinated care organizations that request entry into a service area a fee for conducting a service area entry assessment in an amount reasonably calculated to cover the costs to the authority of administering the assessment.

CAPTIONS

SECTION 5. The unit captions used in this 2025 Act are provided only for the convenience of the reader and do not become part of the statutory law of this state or express any legislative intent in the enactment of this 2025 Act.

APPLICABILITY

SECTION 6. Sections 3 and 4 of this 2025 Act and 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 operative date specified in section 7 of this 2025 Act.

OPERATIVE DATE

SECTION 7. (1) Sections 3 and 4 of this 2025 Act and the amendments to ORS 414.590 by section 1 of this 2025 Act become operative on December 1, 2025.

(2) The Oregon Health Authority may take any action before the operative date specified in subsection (1) of this section that is necessary to enable the authority to exercise, on and after the operative date specified in subsection (1) of this section, all of the duties, functions

and powers conferred on the authority by sections 3 and 4 of this 2025 Act and the amendments to ORS 414.590 by section 1 of this 2025 Act.

EFFECTIVE DATE

SECTION 8. This 2025 Act being necessary for the immediate preservation of the public peace, health and safety, an emergency is declared to exist, and this 2025 Act takes effect on its passage.