SENATE AMENDMENTS TO A-ENGROSSED HOUSE BILL 2020

By COMMITTEE ON HEALTH CARE AND HUMAN SERVICES

May 28

On page 1 of the printed A-engrossed bill, line 3, delete "amending ORS 414.625;".

Delete lines 5 through 27 and delete pages 2 and 3.

On page 4, delete lines 1 through 9 and insert:

"**SECTION 1. (1) As used in this section:**

"(a) 'Assessment' means an on-site quality assessment of an organizational provider that is conducted:

"(A) If the provider has not been accredited by a national organization meeting the quality standards of the Oregon Health Authority;

"(B) By the Oregon Health Authority, another state agency or a contractor on behalf of the authority or another state agency; and

"(C) For the purpose of issuing a certificate of approval.

"(b) 'Organizational provider' means an organization that provides mental health treatment or chemical dependency treatment and is not a coordinated care organization.

"(2) The Oregon Health Authority shall convene a committee, in accordance with ORS 183.333, to advise the authority with respect to the adoption, by rule, of criteria for an assessment. The advisory committee shall advise the authority during the development of the criteria. The advisory committee shall be reconvened as needed to advise the authority with respect to updating the criteria to conform to changes in national accreditation standards or federal requirements for health plans and to advise the authority on opportunities to improve the assessment process. The advisory committee shall include, but is not limited to:

"(a) A representative of each coordinated care organization certified by the authority;

"(b) Representatives of organizational providers;

"(c) Representatives of insurers and health care service contractors that have been accredited by the National Committee for Quality Assurance; and

"(d) Representatives of insurers that offer Medicare Advantage Plans that have been accredited by the National Committee for Quality Assurance.

"(3) The advisory committee described in subsection (2) of this section shall recommend:

"(a) Objective criteria for a shared assessment tool that complies with national accreditation standards and federal requirements for health plans;

"(b) Procedures for conducting an assessment;

"(c) Procedures to eliminate redundant reporting requirements for organizational providers; and

"(d) A process for addressing concerns that arise between assessments regarding compliance with quality standards.

"(4) If another state agency, or a contractor on behalf of the state agency, conducts an

assessment that meets the criteria adopted by the authority under subsection (2) of this section, the authority may rely on the assessment as evidence that the organizational provider meets the assessment requirement for receiving a certificate of approval.

"(5) The authority shall provide a report of an assessment to the organizational provider that was assessed and, upon request, to a coordinated care organization, insurer or health care service contractor.

"(6) If an organizational provider has not been accredited by a national organization that is acceptable to a coordinated care organization, the coordinated care organization shall rely on the assessment conducted in accordance with the criteria adopted under subsection (2) of this section as evidence that the organizational provider meets the assessment requirement.

"(7) This section does not:

"(a) Prohibit a coordinated care organization from requesting information in addition to the report of the assessment if necessary to resolve questions about whether an organizational provider meets the coordinated care organization's policies and procedures for credentialing;

"(b) Prevent a coordinated care organization from requiring its own on-site quality assessment if the authority, another state agency or a contractor on behalf of the authority or another state agency has not conducted an assessment in the preceding 36-month period; or

"(c) Require a coordinated care organization to contract with an organizational provider.

"**SECTION 2. A coordinated care organization, insurer or health care service contractor that relies in good faith on an assessment conducted according to the criteria adopted under section 1 of this 2013 Act shall be immune from civil liability that might otherwise be incurred or imposed.**

"**SECTION 3. The Oregon Health Authority must:**

"(1) Adopt the criteria described in section 1 of this 2013 Act no later than January 1, 2014; and

"(2) Report the progress in implementing section 1 of this 2013 Act to the appropriate interim committees of the Legislative Assembly beginning in September 2013 and at each meeting of the interim committees until the criteria have been adopted and fully implemented.".

In line 10, delete "2" and insert "4".
