House Bill 2022

Sponsored by Representative KENY-GUYER, Senator GELSER, Representative FREDERICK; Representatives GALLEGOS, GREENLICK, NOSSE, PILUSO

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.**

Requires hospital or provider of residential treatment that discharges individual with mental illness to provide case management services to assist individual in transitioning to outpatient mental health treatment. Requires Oregon Health Authority to adopt rules prescribing case management services that must be provided.

Requires policy of group health insurance that provides coverage of hospital or residential treatment expenses to provide coverage of required case management services, as specified by authority.

A BILL FOR AN ACT

Relating to case management services to assist individuals discharged from facilities in transitioning to outpatient mental health treatment; creating new provisions; and amending ORS 443.450 and 743A.168.

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

SECTION 1. Section 2 of this 2015 Act is added to and made a part of ORS 441.015 to 441.063.

SECTION 2. (1) If a patient who is hospitalized for the treatment of a mental, emotional or behavioral disturbance is discharged by the hospital, the hospital staff is responsible for providing case management services to the patient during the patient's transition from inpatient to outpatient treatment including, but not limited to:

(a) Prior to discharge, assessing the patient's level of risk for harm or suicide;

(b) Contacting the patient following discharge to remind the patient of upcoming appointments with the patient's outpatient mental health treatment provider;

(c) Contacting the outpatient mental health treatment provider to determine if the patient attended a scheduled appointment; and

(d) Taking all appropriate steps to ensure that a patient's transition from inpatient treatment to outpatient treatment is as seamless as practicable.

(2) The Oregon Health Authority shall adopt by rule the case management services required by this section.

SECTION 3. ORS 443.450 is amended to read:

443.450. (1) For a residential care facility, residential training facility or residential training home, the Director of Human Services shall adopt rules governing:

(a) The physical properties of the facility or home;

(b) Storage, preparation and serving of food;

(c) Care or training to be provided;

(d) The number, experience and training of the staff; and

(e) Any other factors affecting the care or training provided.

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.

(2) For a residential treatment facility or residential treatment home, the Director of the Oregon Health Authority shall adopt rules governing:

(a) The physical properties of the facility or home;

(b) Storage, preparation and serving of food;

(c) Treatment to be provided;

(d) The number, experience and training of the staff; [*and*]

(e) Any other factors affecting the treatment provided**; and**

(f) The requirements for the discharge of a resident from the facility or home, including case management services that must be provided to the resident during the resident's transition from residential treatment to outpatient treatment including, but not limited to:

(A) Prior to discharge, assessing the resident's level of risk for harm or suicide;

(B) Contacting the discharged resident to remind the discharged resident of upcoming appointments with the discharged resident's outpatient mental health treatment provider;

(C) Contacting the outpatient mental health treatment provider to determine if the discharged resident attended a scheduled appointment; and

(D) Taking all appropriate steps to ensure that a resident's transition from residential treatment to outpatient treatment is as seamless as practicable.

(3) Distinct rules shall be adopted for homes of five or fewer residents, for facilities of six or more but fewer than 16 residents, and for facilities for 16 or more residents. The rules shall differentiate among categories of residents.

(4) For purposes of this section, "categories" refers to different populations of residents, differentiated by, but not limited to, age and need, as defined by the Department of Human Services or the Oregon Health Authority by rule.

SECTION 4. ORS 743A.168 is amended to read:

743A.168. A group health insurance policy providing coverage for hospital or medical expenses shall provide coverage for expenses arising from treatment for chemical dependency, including alcoholism, and for mental or nervous conditions at the same level as, and subject to limitations no more restrictive than, those imposed on coverage or reimbursement of expenses arising from treatment for other medical conditions. The following apply to coverage for chemical dependency and for mental or nervous conditions:

(1) As used in this section:

(a) "Chemical dependency" means the addictive relationship with any drug or alcohol characterized by a physical or psychological relationship, or both, that interferes on a recurring basis with the individual's social, psychological or physical adjustment to common problems. For purposes of this section, "chemical dependency" does not include addiction to, or dependency on, tobacco, tobacco products or foods.

(b) "Facility" means a corporate or governmental entity or other provider of services for the treatment of chemical dependency or for the treatment of mental or nervous conditions.

(c) "Group health insurer" means an insurer, a health maintenance organization or a health care service contractor.

(d) "Program" means a particular type or level of service that is organizationally distinct within a facility.

(e) "Provider" means a person that:

(A) Has met the credentialing requirement of a group health insurer, is otherwise eligible to receive reimbursement for coverage under the policy and is:

(i) A health **care** facility as defined in ORS [*430.010*] **433.060**;

(ii) A residential facility as defined in ORS 430.010;

[*(iii) A day or partial hospitalization program as defined in ORS 430.010;*]

[*(iv)*] **(iii) An individual or a service that provides** an outpatient service as defined in ORS 430.010; or

[*(v)*] **(iv)** An individual behavioral health or medical professional licensed or certified under Oregon law; or

(B) Is a provider organization certified by the Oregon Health Authority under subsection (13) of this section.

(2) The coverage may be made subject to provisions of the policy that apply to other benefits under the policy, including but not limited to provisions relating to deductibles and coinsurance. Deductibles and coinsurance for treatment in health facilities or residential facilities may not be greater than those under the policy for expenses of hospitalization in the treatment of other medical conditions. Deductibles and coinsurance for outpatient treatment may not be greater than those under the policy for expenses of outpatient treatment of other medical conditions.

(3) The coverage may not be made subject to treatment limitations, limits on total payments for treatment, limits on duration of treatment or financial requirements unless similar limitations or requirements are imposed on coverage of other medical conditions. The coverage of eligible expenses may be limited to treatment that is medically necessary as determined under the policy for other medical conditions.

(4)(a) Nothing in this section requires coverage for:

(A) Educational or correctional services or sheltered living provided by a school or halfway house;

(B) A long-term residential mental health program that lasts longer than 45 days;

(C) Psychoanalysis or psychotherapy received as part of an educational or training program, regardless of diagnosis or symptoms that may be present; or

(D) A court-ordered sex offender treatment program.

(b) Notwithstanding paragraph (a)(A) of this subsection, an insured may receive covered outpatient services under the terms of the insured's policy while the insured is living temporarily in a sheltered living situation.

(5) A provider is eligible for reimbursement under this section if:

(a) The provider is approved or certified by the Oregon Health Authority;

(b) The provider is accredited for the particular level of care for which reimbursement is being requested by the Joint Commission on Accreditation of Hospitals or the Commission on Accreditation of Rehabilitation Facilities;

(c) The patient is staying overnight at the facility and is involved in a structured program at least eight hours per day, five days per week; or

(d) The provider is providing a covered benefit under the policy.

(6) Payments may not be made under this section for support groups.

(7)**(a) A policy that provides coverage for hospital expenses shall provide coverage for the expenses of case management services described in section 2 of this 2015 Act.**

(b) A policy that provides coverage for the expenses of residential treatment shall provide coverage for the expenses of case management services described in ORS 443.450 (2)(f).

(c) If specified in the policy, outpatient coverage may include follow-up in-home service or outpatient services. The policy may limit coverage for in-home service to persons who are homebound

under the care of a physician.

(8) Nothing in this section prohibits a group health insurer from managing the provision of benefits through common methods, including but not limited to selectively contracted panels, health plan benefit differential designs, preadmission screening, prior authorization of services, utilization review or other mechanisms designed to limit eligible expenses to those described in subsection (3) of this section.

(9) The Legislative Assembly has found that health care cost containment is necessary and intends to encourage insurance policies designed to achieve cost containment by ensuring that reimbursement is limited to appropriate utilization under criteria incorporated into such policies, either directly or by reference.

(10)(a) Subject to the patient or client confidentiality provisions of ORS 40.235 relating to physicians, ORS 40.240 relating to nurse practitioners, ORS 40.230 relating to psychologists, ORS 40.250 and 675.580 relating to licensed clinical social workers and ORS 40.262 relating to licensed professional counselors and licensed marriage and family therapists, a group health insurer may provide for review for level of treatment of admissions and continued stays for treatment in health facilities, residential facilities, day or partial hospitalization programs and outpatient services by either group health insurer staff or personnel under contract to the group health insurer, or by a utilization review contractor, who shall have the authority to certify for or deny level of payment.

(b) Review shall be made according to criteria made available to providers in advance upon request.

(c) Review shall be performed by or under the direction of a medical or osteopathic physician licensed by the Oregon Medical Board, a psychologist licensed by the State Board of Psychologist Examiners, a clinical social worker licensed by the State Board of Licensed Social Workers or a professional counselor or marriage and family therapist licensed by the Oregon Board of Licensed Professional Counselors and Therapists, in accordance with standards of the National Committee for Quality Assurance or Medicare review standards of the Centers for Medicare and Medicaid Services.

(d) Review may involve prior approval, concurrent review of the continuation of treatment, post-treatment review or any combination of these. However, if prior approval is required, provision shall be made to allow for payment of urgent or emergency admissions, subject to subsequent review. If prior approval is not required, group health insurers shall permit providers, policyholders or persons acting on their behalf to make advance inquiries regarding the appropriateness of a particular admission to a treatment program. Group health insurers shall provide a timely response to such inquiries. Noncontracting providers must cooperate with these procedures to the same extent as contracting providers to be eligible for reimbursement.

(11) Health maintenance organizations may limit the receipt of covered services by enrollees to services provided by or upon referral by providers contracting with the health maintenance organization. Health maintenance organizations and health care service contractors may create substantive plan benefit and reimbursement differentials at the same level as, and subject to limitations no more restrictive than, those imposed on coverage or reimbursement of expenses arising out of other medical conditions and apply them to contracting and noncontracting providers.

(12) Nothing in this section prevents a group health insurer from contracting with providers of health care services to furnish services to policyholders or certificate holders according to ORS 743.531 or 750.005, subject to the following conditions:

(a) A group health insurer is not required to contract with all providers that are eligible for

reimbursement under this section.

(b) An insurer or health care service contractor shall, subject to subsections (2) and (3) of this section, pay benefits toward the covered charges of noncontracting providers of services for the treatment of chemical dependency or mental or nervous conditions. The insured shall, subject to subsections (2) and (3) of this section, have the right to use the services of a noncontracting provider of services for the treatment of chemical dependency or mental or nervous conditions, whether or not the services for chemical dependency or mental or nervous conditions are provided by contracting or noncontracting providers.

(13) The Oregon Health Authority shall establish a process for the certification of an organization described in subsection (1)(e)(B) of this section that:

(a) Is not otherwise subject to licensing or certification by the authority; and

(b) Does not contract with the authority, a subcontractor of the authority or a community mental health program.

(14) The Oregon Health Authority shall adopt by rule standards for the certification provided under subsection (13) of this section to ensure that a certified provider organization offers a distinct and specialized program for the treatment of mental or nervous conditions.

(15) The Oregon Health Authority may adopt by rule an application fee or a certification fee, or both, to be imposed on any provider organization that applies for certification under subsection (13) of this section. Any fees collected shall be paid into the Oregon Health Authority Fund established in ORS 413.101 and shall be used only for carrying out the provisions of subsection (13) of this section.

(16) The intent of the Legislative Assembly in adopting this section is to reserve benefits for different types of care to encourage cost effective care and to ensure continuing access to levels of care most appropriate for the insured's condition and progress. This section does not prohibit an insurer from requiring a provider organization certified by the Oregon Health Authority under subsection (13) of this section to meet the insurer's credentialing requirements as a condition of entering into a contract.

(17) The Director of the Department of Consumer and Business Services and the Oregon Health Authority, after notice and hearing, may adopt reasonable rules not inconsistent with this section that are considered necessary for the proper administration of this section.
