

D R A F T

SUMMARY

Establishes external medical review process for coverage determinations made by coordinated care organizations.

A BILL FOR AN ACT

Relating to external medical reviews; creating new provisions; and amending ORS 414.605 and 414.712.

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

SECTION 1. Section 2 of this 2023 Act is added to and made a part of ORS chapter 414.

SECTION 2. (1) The Oregon Health Authority shall enter into an interagency agreement with the Department of Consumer and Business Services to use the services of an independent review organization that contracts with the department under ORS 743B.253 to provide external medical reviews under ORS 414.712 using the process for external reviews described in ORS 743B.252 (3), (4) and (5).

(2) In an external medical review, an independent review organization may review a determination by a coordinated care organization:

(a) To reduce the duration or scope of a treatment or service;

(b) That a treatment or service is not medically necessary or is experimental;

(c) That the requested treatment or service is not paired with a condition that is funded on the prioritized list of health services developed by the Health Evidence Review Commission under ORS 414.690;

(d) Regarding the impact of the requested treatment or service on

1 **a comorbid condition of the member that is funded on the prioritized**
2 **list of health services; or**

3 **(e) Any other determination that is based on an examination of the**
4 **medical evidence.**

5 **(6) The external review process must:**

6 **(a) Be at the member's option;**

7 **(b) Be offered without cost to the member; and**

8 **(c) Not interrupt the member's continued receipt of benefits pend-**
9 **ing resolution of the appeal if the member files a timely request for**
10 **review.**

11 **SECTION 3.** ORS 414.712 is amended to read:

12 414.712. The Oregon Health Authority shall provide health services under
13 [*ORS 414.591, 414.631 and 414.688 to 414.745*] **this chapter** to eligible persons
14 who are determined eligible for medical assistance as defined in ORS 414.025.

15 The Oregon Health Authority shall also provide the following:

16 (1) Ombudsman services for individuals who receive medical assistance
17 under ORS 411.706 and for recipients who are members of coordinated care
18 organizations. With the concurrence of the Governor and the Oregon Health
19 Policy Board, the Director of the Oregon Health Authority shall appoint
20 ombudsmen and may terminate an ombudsman. Ombudsmen are under the
21 supervision and control of the director. An ombudsman shall serve as a
22 recipient's advocate whenever the recipient or a physician or other medical
23 personnel serving the recipient is reasonably concerned about access to,
24 quality of or limitations on the care being provided by a health care provider
25 or a coordinated care organization. **However, an ombudsman may not act**
26 **as a recipient's representative during any grievance, hearing or ex-**
27 **ternal medical review process.** Recipients shall be informed of the avail-
28 ability of an ombudsman. Ombudsmen shall report to the Governor and the
29 Oregon Health Policy Board in writing at least once each quarter. A report
30 shall include a summary of the services that the ombudsman provided during
31 the quarter and the ombudsman's recommendations for improving ombuds-

1 man services and access to or quality of care provided to eligible persons by
2 health care providers and coordinated care organizations.

3 (2) Case management services in each health care provider organization
4 or coordinated care organization for those individuals who receive assistance
5 under ORS 411.706. Case managers shall be trained in and shall exhibit skills
6 in communication with and sensitivity to the unique health care needs of
7 individuals who receive assistance under ORS 411.706. Case managers shall
8 be reasonably available to assist recipients served by the organization with
9 the coordination of the recipient's health services at the reasonable request
10 of the recipient or a physician or other medical personnel serving the recip-
11 ient. Recipients shall be informed of the availability of case managers.

12 (3) A mechanism, established by rule, for soliciting consumer opinions and
13 concerns regarding accessibility to and quality of the services of each health
14 care provider.

15 (4) A choice of available medical plans and, within those plans, choice
16 of a primary care provider.

17 (5)(a) Due process procedures for any individual whose request for med-
18 ical assistance coverage for any treatment or service is denied **or reduced**
19 or is not acted upon with reasonable promptness. These procedures shall in-
20 clude:

21 (A) An expedited process for cases in which a recipient's medical needs
22 require swift resolution of a dispute[. *An ombudsman described in subsection*
23 *(1) of this section may not act as the recipient's representative during any*
24 *grievance or hearing process*]; **and**

25 (B) **For a request for any treatment or service that is denied or is**
26 **not acted upon with reasonable promptness or that is reduced in du-**
27 **ration or scope by a coordinated care organization, an external med-**
28 **ical review in accordance with section 2 of this 2023 Act.**

29 **SECTION 4.** ORS 414.605 is amended to read:

30 414.605. (1) The Oregon Health Authority shall adopt by rule safeguards
31 for members enrolled in coordinated care organizations that protect against

1 underutilization of services and inappropriate denials of services. In addition
2 to any other consumer rights and responsibilities established by law, each
3 member:

4 (a) Must be encouraged to be an active partner in directing the member's
5 health care and services and not a passive recipient of care.

6 (b) Must be educated about the coordinated care approach being used in
7 the community, including the approach to addressing behavioral health care,
8 and provided with any assistance needed regarding how to navigate the co-
9 ordinated health care system.

10 (c) Must have access to advocates, including qualified peer wellness spe-
11 cialists, peer support specialists, personal health navigators, and qualified
12 community health workers who are part of the member's care team to pro-
13 vide assistance that is culturally and linguistically appropriate to the
14 member's need to access appropriate services and participate in processes
15 affecting the member's care and services.

16 (d) Shall be encouraged within all aspects of the integrated and coordi-
17 nated health care delivery system to use wellness and prevention resources
18 and to make healthy lifestyle choices.

19 (e) Shall be encouraged to work with the member's care team, including
20 providers and community resources appropriate to the member's needs as a
21 whole person.

22 (2) The authority shall establish and maintain an enrollment process for
23 individuals who are dually eligible for Medicare and Medicaid that promotes
24 continuity of care and that allows the member to disenroll from a coordi-
25 nated care organization that fails to promptly provide adequate services and:

26 (a) To enroll in another coordinated care organization of the member's
27 choice; or

28 (b) If another organization is not available, to receive Medicare-covered
29 services on a fee-for-service basis.

30 (3) Members and their providers and coordinated care organizations have
31 the right to appeal decisions about care and services:

1 (a) Through the authority in an expedited manner and in accordance with
2 the contested case procedures in ORS chapter 183; or

3 (b) **Using the external medical review described in section 2 of this**
4 **2023 Act.**

5 (4) A health care entity may not unreasonably refuse to contract with an
6 organization seeking to form a coordinated care organization if the partic-
7 ipation of the entity is necessary for the organization to qualify as a coor-
8 dinated care organization.

9 (5) A health care entity may refuse to contract with a coordinated care
10 organization if the reimbursement established for a service provided by the
11 entity under the contract is below the reasonable cost to the entity for pro-
12 viding the service.

13 (6) A health care entity that unreasonably refuses to contract with a co-
14 ordinated care organization may not receive fee-for-service reimbursement
15 from the authority for services that are available through a coordinated care
16 organization either directly or by contract.

17 (7)(a) The authority shall adopt by rule a process for resolving disputes
18 involving:

19 (A) A health care entity's refusal to contract with a coordinated care
20 organization under subsections (4) and (5) of this section.

21 (B) The termination, extension or renewal of a health care entity's con-
22 tract with a coordinated care organization.

23 (b) The processes adopted under this subsection must include the use of
24 an independent third party arbitrator.

25 (8) A coordinated care organization may not unreasonably refuse to con-
26 tract with a licensed health care provider.

27 (9) The authority shall:

28 (a) Monitor and enforce consumer rights and protections within the
29 Oregon Integrated and Coordinated Health Care Delivery System and ensure
30 a consistent response to complaints of violations of consumer rights or pro-
31 tections.

1 (b) Monitor and report on the statewide health care expenditures and re-
2 commend actions appropriate and necessary to contain the growth in health
3 care costs incurred by all sectors of the system.

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