

Requested by SENATE COMMITTEE ON HEALTH CARE

**PROPOSED AMENDMENTS TO
SENATE BILL 191**

1 In line 2 of the printed bill, after “assistance” insert “; creating new
2 provisions; and amending ORS 414.605 and 414.712”.

3 Delete lines 4 through 9 and insert:

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

6 **“SECTION 2. (1) The Oregon Health Authority shall enter into an
7 interagency agreement with the Department of Consumer and Busi-
8 ness Services to use the services of an independent review organization
9 that contracts with the department under ORS 743B.253 to provide
10 external medical reviews under ORS 414.712 using the process for ex-
11 ternal reviews described in ORS 743B.252 (3), (4) and (5).**

12 **“(2) In an external medical review, an independent review organ-
13 ization may review a determination by a coordinated care organiza-
14 tion:**

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

16 **“(b) That a treatment or service is not medically necessary or is
17 experimental;**

18 **“(c) That the requested treatment or service is not paired with a
19 condition that is funded on the prioritized list of health services de-
20 veloped by the Health Evidence Review Commission under ORS 414.690;**

21 **“(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
4 the 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
9 pending resolution of the appeal if the member files a timely request
10 for review.

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

12 “414.712. The Oregon Health Authority shall provide health services un-
13 der [ORS 414.591, 414.631 and 414.688 to 414.745] **this chapter** to eligible
14 persons who are determined eligible for medical assistance as defined in ORS
15 414.025. 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

1 the quarter and the ombudsman’s recommendations for improving ombuds-
2 man services and access to or quality of care provided to eligible persons by
3 health care providers and coordinated care organizations.

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

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

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

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

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

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

30 “**SECTION 4.** ORS 414.605 is amended to read:

1 “414.605. (1) The Oregon Health Authority shall adopt by rule safeguards
2 for members enrolled in coordinated care organizations that protect against
3 underutilization of services and inappropriate denials of services. In addition
4 to any other consumer rights and responsibilities established by law, each
5 member:

6 “(a) Must be encouraged to be an active partner in directing the member’s
7 health care and services and not a passive recipient of care.

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

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

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

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

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

28 “(a) To enroll in another coordinated care organization of the member’s
29 choice; or

30 “(b) If another organization is not available, to receive Medicare-covered

1 services on a fee-for-service basis.

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

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

6 “(b) **Using the external medical review described in section 2 of this**
7 **2023 Act.**

8 “(4) A health care entity may not unreasonably refuse to contract with
9 an organization seeking to form a coordinated care organization if the par-
10 ticipation of the entity is necessary for the organization to qualify as a co-
11 ordinated care organization.

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

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

20 “(7)(a) The authority shall adopt by rule a process for resolving disputes
21 involving:

22 “(A) A health care entity’s refusal to contract with a coordinated care
23 organization under subsections (4) and (5) of this section.

24 “(B) The termination, extension or renewal of a health care entity’s con-
25 tract with a coordinated care organization.

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

28 “(8) A coordinated care organization may not unreasonably refuse to
29 contract with a licensed health care provider.

30 “(9) The authority shall:

1 “(a) Monitor and enforce consumer rights and protections within the
2 Oregon Integrated and Coordinated Health Care Delivery System and ensure
3 a consistent response to complaints of violations of consumer rights or pro-
4 tections.

5 “(b) Monitor and report on the statewide health care expenditures and
6 recommend actions appropriate and necessary to contain the growth in
7 health care costs incurred by all sectors of the system.”.

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