SB 191-2
(LC 1916)
3/7/23 (LHF/ps)

Requested by SENATE COMMITTEE ON HEALTH CARE

PROPOSED AMENDMENTS TO
SENATE BILL 191

In line 2 of the printed bill, after "assistance" insert "; creating new provisions; and amending ORS 411.095, 414.605 and 414.712".

Delete lines 4 through 9 and insert:

"SECTION 1. Sections 2 to 7 of this 2023 Act are added to and made a part of ORS chapter 414.

"SECTION 2. As used in sections 2 to 7 of this 2023 Act:

"(1) 'Adverse benefit determination' means a denial of, denial of prior authorization for, termination of reduction of or limitation on a health service by the Oregon Health Authority or a coordinated care organization.

"(2) 'Enrollee' means an individual who receives medical assistance, whether or not the individual is a member of a coordinated care organization.

"(3) 'Notice of an adverse benefit determination' means a notice to an enrollee of an adverse benefit determination that:

"(a) Is provided through a notice described in ORS 183.413;

"(b) Results from a coordinated care organization's internal appeal process; or

"(c) Is in response to a grievance filed by an enrollee with the authority or a coordinated care organization.

"SECTION 3. (1) The Oregon Health Authority shall have an ex-

ternal review program that meets the requirements of sections 2 to 7 of this 2023 Act and rules adopted by the authority to carry out the provisions of sections 2 to 7 of this 2023 Act. The external review shall be conducted by an independent review organization that is under contract with the authority to provide external review.

"(2)(a) In an external review, an independent review organization may review an adverse benefit determination by the authority or by a coordinated care organization that:

"(A) Reduces the duration or scope of a health service;

"(B) Finds that a health service is not medically necessary or is experimental;

"(C) Finds that the requested health service is not paired with a condition or that the enrollee's condition for which the health service is requested is not on a prioritized list of health services or within the guidelines developed by the Health Evidence Review Commission under ORS 414.690;

"(D) Finds that the requested treatment or health service does not affect the enrollee's comorbid condition that is funded on the prioritized list of health services; or

"(E) Is based on an examination of the medical evidence.

"(b) An independent review organization may not review the determination of the Health Evidence Review Commission as to the placement of a condition or the pairing of a treatment with a condition on the prioritized list of health services developed by the commission under ORS 414.690.

"(3) The authority shall incur the costs of an independent review organization for conducting external reviews. A coordinated care organization shall be responsible for the coordinated care organization's own costs of responding to a review and providing medical records to the independent review organization.

"(4)(a) When an enrollee requests an external review, the authority shall appoint an independent review organization. When an independent review organization is appointed, the authority or the coordinated care organization that issued the adverse benefit determination shall forward all medical records and other relevant materials to the independent review organization no later than five business days after the appointment or no later than 24 hours after the appointment for expedited reviews under subsection (6) of this section. The authority or the coordinated care organization shall produce additional information as requested by the independent review organization to the extent that the information is reasonably available to the authority or the coordinated care organization. An independent review organization may reverse the adverse benefit determination if the authority or coordinated care organization fails to furnish records, information and materials to the independent review organization in a timely manner.

"(b) Paragraph (a) of this subsection does not require the authority or a coordinated care organization to disclose protected health information to an independent review organization if the disclosure is prohibited by state or federal law.

"(5) An enrollee shall provide any information required by the independent review organization and may submit additional information to the independent review organization no later than five business days after the enrollee's receipt of notification of the appointment of the independent review organization, or no later than 24 hours after receipt in the case of an expedited review under subsection (6) of this section, and the organization must consider the information in its review.

"(6) The authority and the coordinated care organization shall expedite the external review:

"(a) If the adverse benefit determination concerns an admission to

a facility, the availability of care, a continued stay at a facility or a health service for a medical condition if the enrollee received emergency services for the medical condition and was admitted to a facility after receiving the emergency services and has not been discharged from the facility; or

"(b) If a provider with an established clinical relationship with the enrollee certifies in writing and provides supporting documentation that the ordinary time period for external review would seriously jeopardize the life or health of the enrollee or the enrollee's ability to regain maximum function.

"(7) A health service must be continued without reduction if the adverse benefit determination is a termination of, reduction of or limitation on the health service and the enrollee requests an external review no later than ten days after receiving a notice of an adverse benefit determination.

"SECTION 4. (1) The Oregon Health Authority shall contract with independent review organizations as provided in this section for the purpose of providing external reviews under section 3 of this 2023 Act. Contracts shall be let with independent review organizations on a biennial basis. A contract may be renewed if both parties agree.

"(2) The authority shall seek public comment when the authority proposes to enter into a contract with an independent review organization or proposes to renew or not renew a contract.

"(3) When evaluating proposals to contract with independent review organizations, the authority shall consider factors that include but are not limited to an independent review organization's relative expertise, professionalism, quality of compliance with the rules established under subsection (4) of this section, cost and record of past performance.

"(4) The authority shall adopt rules governing independent review organizations that contract with the authority and their conduct. The

rules shall include but need not be limited to:

"(a) Professional qualifications of health care providers, physicians or contract specialists making external review determinations;

"(b) Criteria requiring independent review organizations to demonstrate protections against bias and conflicts of interest;

"(c) Procedures for conducting external reviews;

"(d) Procedures for complaint investigations;

"(e) Procedures for ensuring the confidentiality of medical records transmitted to independent review organizations for use in external reviews;

"(f) Fairness of procedures used by independent review organizations;

"(g) Fees for external reviews;

"(h) Timelines for decision-making and notice to the parties in an external review; and

"(i) Quality assurance mechanisms to ensure timeliness and quality of external reviews.

"(5) The authority shall develop procedures for randomly assigning requests for external reviews filed by enrollees to independent review organizations. The procedures may allow a coordinated care organization or the authority no more than one opportunity to reject the assignment of an independent review organization in a particular case.

"SECTION 5. (1) A notice of an adverse benefit determination must inform an enrollee of the availability of external review and the process for requesting external review.

"(2) An enrollee may request an external review of an adverse benefit determination not later than the 75th day after receipt of a notice of an adverse benefit determination. The request must be made in the form and manner prescribed by the Oregon Health Authority.

"(3)(a) If the internal appeal process of a coordinated care organ-

ization meets the requirements for an external review under section 3 of this 2023 Act, an enrollee who is a member of the coordinated care organization is eligible for external review only if the enrollee has exhausted the coordinated care organization's internal appeal process.

"(b) The authority may screen a request for an external review to verify that the enrollee has exhausted the coordinated care organization's internal appeal process in accordance with this subsection and to verify that the adverse benefit determination is within the independent review organization's scope of review under section 3 (2) of this 2023 Act. A enrollee is entitled to a hearing under ORS chapter 183 to contest a decision by the authority denying external review under this subsection.

"(4) An enrollee may request a hearing under ORS 411.095 to contest the decision of an independent review organization. An enrollee is not entitled to external review if the enrollee requested a hearing under ORS 411.095 on the same issue and a final order has been issued adverse to the enrollee.

"SECTION 6. (1) An independent review organization shall perform the following duties when appointed under section 3 of this 2023 Act to review a dispute between an enrollee and the Oregon Health Authority or a coordinated care organization:

"(a) Decide whether the dispute pertains to an adverse benefit determination and notify the enrollee and the authority or the coordinated care organization in writing of the decision. If the independent review organization decides that the dispute does not pertain to an adverse benefit determination, the independent review organization shall notify the enrollee of the right to request a hearing under ORS 411.095 to contest the decision.

"(b) Appoint a reviewer or reviewers as determined appropriate by the independent review organization. At least one reviewer must be a

clinician in the same or a similar specialty as the provider who prescribed the health service that is under review.

"(c) Notify the enrollee of information that the enrollee is required to provide and any additional information the enrollee may provide and when the information must be submitted.

"(d) Notify the authority or the coordinated care organization of additional information the independent review organization requires and when the information must be submitted as provided in section 3 of this 2023 Act.

"(e) Decide the dispute relating to the adverse benefit determination and issue the decision in writing.

"(2) A decision by an independent review organization shall be based on expert medical judgment after consideration of the enrollee's medical record, the recommendations of each of the enrollee's providers, relevant medical, scientific and cost-effectiveness evidence and standards of medical practice in the United States.

"(3) When review is expedited, the independent review organization shall issue a decision not later than the third day after the date on which the enrollee applies to the authority for an expedited review or the authority orders an expedited review.

"(4) When a review is not expedited, the independent review organization shall issue a decision not later than the 30th day after the enrollee applies to the authority for a review or the authority orders a review.

"(5) An independent review organization shall file synopses of its decisions with the authority according to the format and other requirements established by the authority. The synopses shall exclude information that is confidential, that is otherwise exempt from disclosure under ORS 192.345 and 192.355 or that may otherwise allow identification of an enrollee. The authority shall make the synopses

public.

"(6) An independent review organization, a clinical reviewer working on behalf of an independent review organization or an employee, agent or contractor of an independent review organization may not be liable for damages to any person for any opinions rendered or acts or omissions performed within the scope of the organization's duties under the law during or upon completion of an external review, unless the opinion was rendered or act or omission performed in bad faith or with gross negligence.

"SECTION 7. (1) The Oregon Health Authority or a coordinated care organization shall comply in a timely manner with a decision of an independent review organization under section 6 of this 2023 Act that reverses, in whole or in part, an adverse benefit determination.

"(2) A decision of an independent review organization is admissible in any legal proceeding involving the authority, the coordinated care organization or the enrollee that involves the disputed issues subject to external review, including a hearing under ORS 411.095.

"SECTION 8. ORS 411.095 is amended to read:

"411.095. (1)(a) Except as provided in paragraph (b) of this subsection, when the Department of Human Services or the Oregon Health Authority changes a benefit standard that results in the reduction, suspension or closure of a grant of public assistance or a grant of medical assistance, the department or the authority shall mail a notice of intended action to each recipient affected by the change at least 30 days before the effective date of the action.

"(b) If the department or the authority has fewer than 60 days before the effective date to implement a proposed change described in paragraph (a) of this subsection, the department or the authority shall mail a notice of intended action to each recipient affected by the change as soon as practicable but at least 10 working days before the effective date of the action.

"(2) When the federal government changes a benefit or standard that results in the suspension or closure of supplemental nutrition assistance issued under ORS 411.806 to 411.845 or 413.500 for the entire caseload or a significant portion of the caseload of recipients in this state, the department and the authority are not required to mail a notice of intended action to each recipient affected by the change but shall publicize the change using one or more of the following methods:

"(a) Informing the public through the news media.

"(b) Placing posters in the offices that serve affected recipients, in the locations where supplemental nutrition assistance is issued to affected recipients and at other sites frequented by affected recipients.

"(c) Mailing a general notice to the households of affected recipients.

"(3) **The department or the authority shall provide an opportunity for a hearing under ORS chapter 183** when**:**

"(a) The department or the authority conducts a hearing pursuant to ORS 416.310 to 416.340 and 416.510 to 416.830 and 416.990 [*or when the department or the authority*]**;**

"(b) The department or the authority proposes to deny, reduce, suspend or terminate a grant of public assistance, a grant of medical assistance or a support service payment used to support participation in the job opportunity and basic skills program[*, the department or the authority shall provide an opportunity for a hearing under ORS chapter 183*]**; or**

"(c) The authority refers an adverse benefit determination to an independent review organization under section 3 of this 2023 Act and the decision of the independent review organization is adverse to the recipient.

"(4) When emergency assistance or the continuation of assistance pending a hearing on the reduction, suspension or termination of public assistance, medical assistance or a support service payment used to support participation in the job opportunity and basic skills program is denied, and the

applicant for or recipient of public assistance, medical assistance or a support service payment requests a hearing on the denial, an expedited hearing on the denial shall be held within five working days after the request. A written decision shall be issued within three working days after the hearing is held.

"(5) For purposes of this section, a reduction or termination of services resulting from an assessment for service eligibility as defined in ORS 411.099 is a grant of public assistance.

"(6) Adoption of rules, conduct of hearings and issuance of orders and judicial review of rules and orders shall be in accordance with ORS chapter 183.

"SECTION 9. ORS 414.712 is amended to read:

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

"(1) Ombudsman services for individuals who receive medical assistance under ORS 411.706 and for recipients who are members of coordinated care organizations. With the concurrence of the Governor and the Oregon Health Policy Board, the Director of the Oregon Health Authority shall appoint ombudsmen and may terminate an ombudsman. Ombudsmen are under the supervision and control of the director. An ombudsman shall serve as a recipient's advocate whenever the recipient or a physician or other medical personnel serving the recipient is reasonably concerned about access to, quality of or limitations on the care being provided by a health care provider or a coordinated care organization. Recipients shall be informed of the availability of an ombudsman. Ombudsmen shall report to the Governor and the Oregon Health Policy Board in writing at least once each quarter. A report shall include a summary of the services that the ombudsman provided during the quarter and the ombudsman's recommendations for improving

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

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

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

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

"(5) Due process procedures for any individual whose request for medical assistance coverage for any treatment or service is denied **or reduced** or is not acted upon with reasonable promptness. These procedures shall include**:**

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

"(b) An external medical review in accordance with sections 3, 5 and 6 of this 2023 Act.

"SECTION 10. ORS 414.605 is amended to read:

"414.605. (1) The Oregon Health Authority shall adopt by rule safeguards for members enrolled in coordinated care organizations that protect against underutilization of services and inappropriate denials of services. In addition

to any other consumer rights and responsibilities established by law, each member:

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

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

"(c) Must have access to advocates, including qualified peer wellness specialists, peer support specialists, personal health navigators, and qualified community health workers who are part of the member's care team to provide assistance that is culturally and linguistically appropriate to the member's need to access appropriate services and participate in processes affecting the member's care and services.

"(d) Shall be encouraged within all aspects of the integrated and coordinated health care delivery system to use wellness and prevention resources and to make healthy lifestyle choices.

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

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

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

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

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

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

"(b) Using the coordinated care organization's internal appeal process, if applicable; and

"(c) Using the external medical review process described in sections 3, 5 and 6 of this 2023 Act.

"(4) A health care entity may not unreasonably refuse to contract with an organization seeking to form a coordinated care organization if the participation of the entity is necessary for the organization to qualify as a coordinated care organization.

"(5) A health care entity may refuse to contract with a coordinated care organization if the reimbursement established for a service provided by the entity under the contract is below the reasonable cost to the entity for providing the service.

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

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

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

"(B) The termination, extension or renewal of a health care entity's contract with a coordinated care organization.

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

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

"(9) The authority shall:

"(a) Monitor and enforce consumer rights and protections within the

Oregon Integrated and Coordinated Health Care Delivery System and ensure a consistent response to complaints of violations of consumer rights or protections.

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