House Bill 3686

Sponsored by Representatives HOYLE, FREEMAN, NATHANSON, Senator KRUSE; Representatives BARNHART, BENTZ, BERGER, BOONE, BREWER, CAMERON, CANNON, CONGER, COWAN, DEMBROW, DOHERTY, GARRARD, GILLIAM, GREENLICK, HANNA, HOLVEY, HUFFMAN, JENSON, JOHNSON, KENNEMER, KOTEK, MATTHEWS, NOLAN, SHEEHAN, THATCHER, WAND, WEIDNER, WHISNANT, WINGARD, WITT, Senators BATES, GIROD

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 Oregon Health Authority, Department of Human Services and Department of Consumer and Business Services to report to Legislative Assembly on steps taken to streamline regulatory requirements in specified areas and reduce administrative burdens on persons contracting with or regulated by authority and departments. Sunsets February 28, 2013.

Declares emergency, effective on passage.

A BILL FOR AN ACT

Relating to regulatory streamlining; and declaring an emergency.

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

SECTION 1. The Oregon Health Authority shall take all steps necessary and practicable to streamline administrative requirements imposed by the authority and to reduce administrative burdens on entities that contract with or are regulated by the authority. The authority shall report to the 2013 regular session of the Legislative Assembly on the progress of:

(1) Improving and refining the provider capacity report that the authority uses to measure provider capacity.

(2) Streamlining and reducing the frequency of required reporting of medical assistance recipient complaints and appeals.

(3) If permitted by federal law, allowing a managed care organization to contact a provider about a member's complaint without obtaining consent from the member.

(4) Obtaining federal approval necessary to allow managed care organizations, under appropriate circumstances, to provide member handbooks electronically.

(5) Discontinuing the production of member handbooks for medical assistance recipients who are enrolled in managed care organizations that produce handbooks for enrollees.

(6) Reducing cyclical enrollment and disenrollment of medical assistance recipients between different managed care organizations and fee-for-service providers.

(7) Allowing managed care organizations greater flexibility in determining the best means for communicating with their members.

(8) Discontinuing the sending of medical cards to recipients who receive identification cards from a managed care organization.

(9) Streamlining the process for the approval of forms used by managed care organizations to reduce the number of forms that require review and approval by the authority.

(10) Collecting input and performing analyses for the purpose of revising and simplifying

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.

consent forms and the process for obtaining approval of consent forms with particular attention to the Hysterectomy/Sterilization consent forms.

(11) Improving the process for sharing information about medical assistance recipients between fully capitated health plans and less than fully capitated health plans, dental care organizations, mental health organizations and physician care organizations to better integrate care.

(12) Allowing pharmacies to bill durable medical equipment on the point of sale system as a pharmacy claim.

(13) Procuring durable medical equipment for fee-for-service clients through retail pharmacy outlets using the pharmacy benefits manager if less costly.

(14) Allowing income verification for the medical assistance eligibility determination process to be done through electronic payment systems.

(15) Developing program integrity initiatives to strengthen the eligibility determination process for state medical assistance.

(16) Requiring all managed care organizations to contract with hospitals using a payment methodology that is uniform or prohibiting organizations from contracting with hospitals using payment methodologies that do not ensure consistent, predictable costs and payments.

(17) Allowing providers to use clinical practice guidelines from on-site references.

(18) Seeking federal approval to mandate that all medical assistance recipients enroll in managed care organizations.

(19) Improving the provision of exceptional needs care coordination by managed care organizations.

(20) Coordinating and collaborating with the Department of Consumer and Business Services to align reporting requirements imposed by the authority and the department on entities regulated by or contracting with both agencies, to improve efficiency to the greatest extent practicable.

(21) Creating a streamlined and uniform process for certifying the accuracy of claims in order to reduce administrative burdens on providers.

(22) Taking steps to align medical assistance billing and coding requirements with the billing and coding requirements for Medicare to reduce the administrative burden on providers.

(23) Improving the process for verifying client exemptions from copayments to provide information more readily and efficiently to providers.

(24) Proactively researching maternity encounter claims to ensure that the claims trigger payments and identifying additional system changes so that managed care organizations can accurately track and receive payments.

(25) Taking steps to align medical assistance and Medicare enrollment policies.

(26) No later than December 31, 2011, reviewing claim edits and the Medicaid management information system configuration to allow prioritized list line-level denials and payments for diagnosis and treatment pairs.

(27) Working with providers and stakeholders to reduce the no-show rate of medical assistance recipients for health care appointments, with particular emphasis on recipients who require translator services.

(28) Identifying best practices in the treatment of chronic pain to reduce the overutilization of ineffective health treatments.

(29) Allowing medical assistance recipients to purchase over-the-counter medications without requiring a prescription.

(30) Transitioning to the use of National Provider Identification numbers and away from the use of Oregon-specific provider numbers for billing medical assistance claims.

(31) No later than January 1, 2012, implementing policies to ensure the transition of recipients who are ages 16 to 26 from drug coverage under the medical assistance program to drug coverage available through the parents' commercial coverage.

(32) Working with the Centers for Medicare and Medicaid Services to relax the 30-minute rule, which requires all medications to be administered within 30 minutes of the scheduled time and has the effect of complicating nurse staffing at hospitals.

(33) Working with stakeholders to reduce the redundancy of the reporting that is required for medical treatment of children in foster care.

(34) Amending administrative rules and managed care organization contracts to align prior authorization processing times for drugs with Medicare Part D processing times and requiring three-day supplies to be furnished in emergencies while a prior authorization request is being processed.

(35) Reviewing current prior authorization requirements and comparing the requirements to commercial insurance and Medicare requirements, with the goal of enhancing the Medicaid management information system's capability to allow for direct entry of prior authorization requests and immediate notification.

(36) Aligning and streamlining Medicaid and Medicare credentialing processes to avoid duplication and exploring credentialing through an Internet-based service.

(37) Making recommendations for using Medicare payment methodologies for medical assistance claims, particularly with respect to ambulance service providers.

(38) Streamlining data request and reporting requirements to ensure that providers have maximum time for direct patient care and are not subject to duplicative or excessive reporting requirements.

(39) Streamlining the 2012 Tobacco Cessation Minimum Standards of Service to obtain the information in the most effective and least burdensome manner.

(40) Streamlining encounter data reporting.

(41) Reducing the frequency and burden of enrollment verification reporting.

(42) Streamlining on-site performance reviews and performance measure reporting and aligning quality reporting with Medicare guidelines to the extent practicable.

(43) Reducing the frequency of reporting on financial solvency.

(44) Engaging stakeholders in reviewing eligibility coverage start and end dates to avoid changes to eligibility during the course of a month that result in services being provided to ineligible clients.

(45) Exploring eligibility verification through a clearinghouse.

(46) Improving procedures to assign Medicaid identification numbers to avoid the frequent reassignment of numbers.

(47) Developing a uniform statewide process for the certification of addiction and mental health treatment providers.

(48) Streamlining county mental health program and provider site and certification reviews.

(49) Allowing county mental health programs to approve variances for subcontractors,

subject to notification to the authority.

(50) Improving and clarifying the process for the revocation or nonrenewal of a certificate of approval for a county mental health program or other mental health provider.

(51) Recommending legislative changes to extend licensing periods to every two years for adult foster homes and every three years for residential treatment homes and facilities.

(52) Extending the due date for the local mental health biennial implementation plan to six months after passage of the legislatively adopted budget.

(53) Compiling a report on the success of the Oregon Web Infrastructure for Treatment Services system as an alternative to the Client Process Monitoring System.

(54) Taking steps to reduce the financial barriers to acquiring health information technology by providers of addiction and mental health treatment.

(55) Taking steps to align the financial reporting requirements between and throughout the authority and the Department of Human Services.

SECTION 2. The Department of Human Services shall take all steps necessary and practicable to streamline administrative requirements imposed by the department and to reduce administrative burdens on entities that contract with or are regulated by the department. The department shall report to the 2013 regular session of the Legislative Assembly on the progress of eliminating duplicative reporting requirements for enrolling individuals into the developmental disabilities foster care system and on the feasibility of converting to a fully paperless reporting system.

SECTION 3. (1) The Department of Consumer and Business Services shall take all steps necessary and practicable to streamline administrative requirements imposed by the department and to reduce administrative burdens on entities that are regulated by the department. The department shall report to the 2013 regular session of the Legislative Assembly on:

(a) The steps that were taken to reduce the notice requirements imposed on carriers by combining, streamlining or eliminating notice requirements.

(b) The results of the department's evaluation of the usefulness of the reports that must be filed by carriers, identification of any reports that were discontinued as a result of the evaluation or any alternative mechanisms adopted by the department to reduce the administrative burden on carriers in the reporting of data.

(c) Recommendations for legislative changes to improve consistency throughout the Insurance Code.

(2) The department shall report to the appropriate interim committees of the Legislative Assembly upon the adoption by the United States Department of Health and Human Services of the essential health benefits requirements and shall present a comparison of the federal requirements to the health insurance coverage that is required by Oregon law.

SECTION 4. Sections 1 to 3 of this 2011 Act are repealed on February 28, 2013.

SECTION 5. This 2011 Act being necessary for the immediate preservation of the public peace, health and safety, an emergency is declared to exist, and this 2011 Act takes effect on its passage.
