

Senate Bill 137

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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**.

Prohibits coordinated care organization from contracting with any entity to assume risk of providing behavioral health services or to assume responsibility for utilization management, care coordination, denials of service, grievances or appeals. Specifies requirements for denials of services.

Requires Oregon Health Authority to adopt rules governing utilization management of behavioral health services, network adequacy and procedures for members to file grievances and appeals directly with authority.

Requires coordinated care organization to provide specified services to member who is hospitalized for behavioral health condition or who presents to emergency department needing behavioral health services.

Repeals requirement that coordinated care organizations contract with community mental health programs.

A BILL FOR AN ACT

Relating to behavioral health services provided by coordinated care organizations; creating new provisions; and amending ORS 414.153, 414.625, 414.635 and 414.766.

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

SECTION 1. Sections 2 and 3 of this 2019 Act are added to and made a part of ORS chapter 414.

SECTION 2. (1) A coordinated care organization may not contract with a prepaid managed care health services organization or other public or private entity to assume the risk of providing behavioral health services to the members of the coordinated care organization or to be responsible for any of the following with respect to behavioral health services provided to the members of the coordinated care organization:

(a) Managing the utilization of services;

(b) Coordinating care;

(c) Denying services; or

(d) Handling grievances and appeals by members.

(2)(a) A notice denying a behavioral health service must:

(A) Include a recommendation for at least one alternative treatment and guidance on how to obtain the alternative treatment.

(B) Be issued within 24 hours of a request for a service to treat an urgent or emergency condition.

(b) If a member does not have timely access in the member's community to the alternative treatment recommended under paragraph (a) of this subsection, the coordinated care organization must authorize the next highest level of care that is appropriate for the member.

SECTION 3. The Oregon Health Authority shall adopt rules:

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.

1 **(1) Specifying the behavioral health services that may be subject to prior authorization**
 2 **or other utilization management. A coordinated care organization may not require utilization**
 3 **management for a behavioral health service that is not specified by rule.**

4 **(2) For measuring and evaluating network adequacy under ORS 414.645 that are consist-**
 5 **ent with rules for network adequacy requirements under ORS 743B.505.**

6 **(3) Establishing a procedure by which a member of a coordinated care organization may**
 7 **file a grievance or request a contested case proceeding directly with the authority without**
 8 **having first filed a grievance or request for contested case proceeding with the coordinated**
 9 **care organization.**

10 **SECTION 4.** ORS 414.153 is amended to read:

11 414.153. In order to make advantageous use of the system of public health care and services
 12 available through local health departments and other publicly supported programs and to ensure
 13 access to public health care and services through contract under ORS chapter 414, the state shall:

14 (1) Unless cause can be shown why such an agreement is not feasible, require and approve
 15 agreements between coordinated care organizations and publicly funded providers for authorization
 16 of payment for point of contact services in the following categories:

- 17 (a) Immunizations;
- 18 (b) Sexually transmitted diseases; and
- 19 (c) Other communicable diseases;

20 (2) Allow members of coordinated care organizations to receive from fee-for-service providers:

- 21 (a) Family planning services;
- 22 (b) Human immunodeficiency virus and acquired immune deficiency syndrome prevention ser-
- 23 vices; and
- 24 (c) Maternity case management if the Oregon Health Authority determines that a coordinated
- 25 care organization cannot adequately provide the services;

26 (3) Encourage and approve agreements between coordinated care organizations and publicly
 27 funded providers for authorization of and payment for services in the following categories:

- 28 (a) Maternity case management;
- 29 (b) Well-child care;
- 30 (c) Prenatal care;
- 31 (d) School-based clinics;
- 32 (e) Health care and services for children provided through schools and Head Start programs;
- 33 and
- 34 (f) Screening services to provide early detection of health care problems among low income
- 35 women and children, migrant workers and other special population groups; and

36 *[(4) Recognize the responsibility of counties under ORS 430.620 to operate community mental health*
 37 *programs by requiring a written agreement between each coordinated care organization and the local*
 38 *mental health authority in the area served by the coordinated care organization, unless cause can be*
 39 *shown why such an agreement is not feasible under criteria established by the Oregon Health Au-*
 40 *thority. The written agreements:]*

41 *[(a) May not prevent coordinated care organizations from contracting with other public or private*
 42 *providers for mental health or chemical dependency services;]*

43 *[(b) Must include agreed upon outcomes; and]*

44 *[(c) Must describe the authorization and payments necessary to maintain the mental health safety*
 45 *net system and to maintain the efficient and effective management of the following responsibilities of*

1 *local mental health authorities, with respect to the service needs of members of the coordinated care*
 2 *organization.;*

3 [(A) *Management of children and adults at risk of entering or who are transitioning from the*
 4 *Oregon State Hospital or from residential care.;*

5 [(B) *Care coordination of residential services and supports for adults and children.;*

6 [(C) *Management of the mental health crisis system.;*

7 [(D) *Management of community-based specialized services, including but not limited to supported*
 8 *employment and education, early psychosis programs, assertive community treatment or other types of*
 9 *intensive case management programs and home-based services for children; and]*

10 [(E) *Management of specialized services to reduce recidivism of individuals with mental illness in*
 11 *the criminal justice system.;*

12 **SECTION 5.** ORS 414.625, as amended by section 3, chapter 49, Oregon Laws 2018, is amended
 13 to read:

14 414.625. (1) The Oregon Health Authority shall adopt by rule the qualification criteria and re-
 15 quirements for a coordinated care organization and shall integrate the criteria and requirements
 16 into each contract with a coordinated care organization. Coordinated care organizations may be
 17 local, community-based organizations or statewide organizations with community-based participation
 18 in governance or any combination of the two. Coordinated care organizations may contract with
 19 counties or with other public or private entities to provide services to members, **subject to section**
 20 **2 of this 2019 Act.** The authority may not contract with only one statewide organization. A coord-
 21 inated care organization may be a single corporate structure or a network of providers organized
 22 through contractual relationships. The criteria and requirements adopted by the authority under this
 23 section must include, but are not limited to, a requirement that the coordinated care organization:

24 (a) Have demonstrated experience and a capacity for managing financial risk and establishing
 25 financial reserves.

26 (b) Meet the following minimum financial requirements:

27 (A) Maintain restricted reserves of \$250,000 plus an amount equal to 50 percent of the coordi-
 28 nated care organization's total actual or projected liabilities above \$250,000.

29 (B) Maintain a net worth in an amount equal to at least five percent of the average combined
 30 revenue in the prior two quarters of the participating health care entities.

31 (C) Expend a portion of the annual net income or reserves of the coordinated care organization
 32 that exceed the financial requirements specified in this paragraph on services designed to address
 33 health disparities and the social determinants of health consistent with the coordinated care
 34 organization's community health improvement plan and transformation plan and the terms and con-
 35 ditions of the Medicaid demonstration project under section 1115 of the Social Security Act (42
 36 U.S.C. 1315).

37 (c) Operate within a fixed global budget and, by January 1, 2023, spend on primary care, as de-
 38 fined in section 2, chapter 575, Oregon Laws 2015, at least 12 percent of the coordinated care
 39 organization's total expenditures for physical and mental health care provided to members, except
 40 for expenditures on prescription drugs, vision care and dental care.

41 (d) Develop and implement alternative payment methodologies that are based on health care
 42 quality and improved health outcomes.

43 (e) Coordinate the delivery of physical health care, mental health and chemical dependency
 44 services, oral health care and covered long-term care services.

45 (f) Engage community members and health care providers in improving the health of the com-

1 munity and addressing regional, cultural, socioeconomic and racial disparities in health care that
2 exist among the coordinated care organization's members and in the coordinated care organization's
3 community.

4 (2) In addition to the criteria and requirements specified in subsection (1) of this section, the
5 authority must adopt by rule requirements for coordinated care organizations contracting with the
6 authority so that:

7 (a) Each member of the coordinated care organization receives integrated person centered care
8 and services designed to provide choice, independence and dignity.

9 (b) Each member has a consistent and stable relationship with a care team that is responsible
10 for comprehensive care management and service delivery.

11 (c) The supportive and therapeutic needs of each member are addressed in a holistic fashion,
12 using patient centered primary care homes, behavioral health homes or other models that support
13 patient centered primary care and behavioral health care and individualized care plans to the extent
14 feasible.

15 (d) Members receive comprehensive transitional care, including appropriate follow-up, when en-
16 tering and leaving an acute care facility or a long term care setting.

17 (e) Members receive assistance in navigating the health care delivery system and in accessing
18 community and social support services and statewide resources, including through the use of certi-
19 fied health care interpreters and qualified health care interpreters, as those terms are defined in
20 ORS 413.550.

21 (f) Services and supports are geographically located as close to where members reside as possi-
22 ble and are, if available, offered in nontraditional settings that are accessible to families, diverse
23 communities and underserved populations.

24 (g) Each coordinated care organization uses health information technology to link services and
25 care providers across the continuum of care to the greatest extent practicable and if financially vi-
26 able.

27 (h) Each coordinated care organization complies with the safeguards for members described in
28 ORS 414.635.

29 (i) Each coordinated care organization convenes a community advisory council that meets the
30 criteria specified in ORS 414.627.

31 (j) Each coordinated care organization prioritizes working with members who have high health
32 care needs, multiple chronic conditions, mental illness or chemical dependency and involves those
33 members in accessing and managing appropriate preventive, health, remedial and supportive care
34 and services, including the services described in ORS 414.766, to reduce the use of avoidable emer-
35 gency room visits and hospital admissions.

36 (k) Members have a choice of providers within the coordinated care organization's network and
37 that providers participating in a coordinated care organization:

38 (A) Work together to develop best practices for care and service delivery to reduce waste and
39 improve the health and well-being of members.

40 (B) Are educated about the integrated approach and how to access and communicate within the
41 integrated system about a patient's treatment plan and health history.

42 (C) Emphasize prevention, healthy lifestyle choices, evidence-based practices, shared decision-
43 making and communication.

44 (D) Are permitted to participate in the networks of multiple coordinated care organizations.

45 (E) Include providers of specialty care.

1 (F) Are selected by coordinated care organizations using universal application and credentialing
2 procedures and objective quality information and are removed if the providers fail to meet objective
3 quality standards.

4 (G) Work together to develop best practices for culturally appropriate care and service delivery
5 to reduce waste, reduce health disparities and improve the health and well-being of members.

6 (L) Each coordinated care organization reports on outcome and quality measures adopted under
7 ORS 414.638 and participates in the health care data reporting system established in ORS 442.464
8 and 442.466.

9 (m) Each coordinated care organization uses best practices in the management of finances,
10 contracts, claims processing, payment functions and provider networks.

11 (n) Each coordinated care organization participates in the learning collaborative described in
12 ORS 413.259 (3).

13 (o) Each coordinated care organization has a governing body that complies with section 2,
14 chapter 49, Oregon Laws 2018, and that includes:

15 (A) At least one member representing persons that share in the financial risk of the organiza-
16 tion;

17 (B) A representative of a dental care organization selected by the coordinated care organization;

18 (C) The major components of the health care delivery system;

19 (D) At least two health care providers in active practice, including:

20 (i) A physician licensed under ORS chapter 677 or a nurse practitioner certified under ORS
21 678.375, whose area of practice is primary care; and

22 (ii) A mental health or chemical dependency treatment provider;

23 (E) At least two members from the community at large, to ensure that the organization's
24 decision-making is consistent with the values of the members and the community; and

25 (F) At least one member of the community advisory council.

26 (p) Each coordinated care organization's governing body establishes standards for publicizing
27 the activities of the coordinated care organization and the organization's community advisory
28 councils, as necessary, to keep the community informed.

29 (3) The authority shall consider the participation of area agencies and other nonprofit agencies
30 in the configuration of coordinated care organizations.

31 (4) In selecting one or more coordinated care organizations to serve a geographic area, the au-
32 thority shall:

33 (a) For members and potential members, optimize access to care and choice of providers;

34 (b) For providers, optimize choice in contracting with coordinated care organizations; and

35 (c) Allow more than one coordinated care organization to serve the geographic area if necessary
36 to optimize access and choice under this subsection.

37 (5) On or before July 1, 2014, each coordinated care organization must have a formal contractual
38 relationship with any dental care organization that serves members of the coordinated care organ-
39 ization in the area where they reside.

40 **SECTION 6.** ORS 414.625, as amended by section 14, chapter 489, Oregon Laws 2017, and sec-
41 tion 4, chapter 49, Oregon Laws 2018, is amended to read:

42 414.625. (1) The Oregon Health Authority shall adopt by rule the qualification criteria and re-
43 quirements for a coordinated care organization and shall integrate the criteria and requirements
44 into each contract with a coordinated care organization. Coordinated care organizations may be
45 local, community-based organizations or statewide organizations with community-based participation

1 in governance or any combination of the two. Coordinated care organizations may contract with
2 counties or with other public or private entities to provide services to members, **subject to section**
3 **2 of this 2019 Act.** The authority may not contract with only one statewide organization. A coordi-
4 nated care organization may be a single corporate structure or a network of providers organized
5 through contractual relationships. The criteria and requirements adopted by the authority under this
6 section must include, but are not limited to, a requirement that the coordinated care organization:

7 (a) Have demonstrated experience and a capacity for managing financial risk and establishing
8 financial reserves.

9 (b) Meet the following minimum financial requirements:

10 (A) Maintain restricted reserves of \$250,000 plus an amount equal to 50 percent of the coordi-
11 nated care organization's total actual or projected liabilities above \$250,000.

12 (B) Maintain a net worth in an amount equal to at least five percent of the average combined
13 revenue in the prior two quarters of the participating health care entities.

14 (C) Expend a portion of the annual net income or reserves of the coordinated care organization
15 that exceed the financial requirements specified in this paragraph on services designed to address
16 health disparities and the social determinants of health consistent with the coordinated care
17 organization's community health improvement plan and transformation plan and the terms and con-
18 ditions of the Medicaid demonstration project under section 1115 of the Social Security Act (42
19 U.S.C. 1315).

20 (c) Operate within a fixed global budget and spend on primary care, as defined by the authority
21 by rule, at least 12 percent of the coordinated care organization's total expenditures for physical
22 and mental health care provided to members, except for expenditures on prescription drugs, vision
23 care and dental care.

24 (d) Develop and implement alternative payment methodologies that are based on health care
25 quality and improved health outcomes.

26 (e) Coordinate the delivery of physical health care, mental health and chemical dependency
27 services, oral health care and covered long-term care services.

28 (f) Engage community members and health care providers in improving the health of the com-
29 munity and addressing regional, cultural, socioeconomic and racial disparities in health care that
30 exist among the coordinated care organization's members and in the coordinated care organization's
31 community.

32 (2) In addition to the criteria and requirements specified in subsection (1) of this section, the
33 authority must adopt by rule requirements for coordinated care organizations contracting with the
34 authority so that:

35 (a) Each member of the coordinated care organization receives integrated person centered care
36 and services designed to provide choice, independence and dignity.

37 (b) Each member has a consistent and stable relationship with a care team that is responsible
38 for comprehensive care management and service delivery.

39 (c) The supportive and therapeutic needs of each member are addressed in a holistic fashion,
40 using patient centered primary care homes, behavioral health homes or other models that support
41 patient centered primary care and behavioral health care and individualized care plans to the extent
42 feasible.

43 (d) Members receive comprehensive transitional care, including appropriate follow-up, when en-
44 tering and leaving an acute care facility or a long term care setting.

45 (e) Members receive assistance in navigating the health care delivery system and in accessing

1 community and social support services and statewide resources, including through the use of certi-
2 fied health care interpreters and qualified health care interpreters, as those terms are defined in
3 ORS 413.550.

4 (f) Services and supports are geographically located as close to where members reside as possi-
5 ble and are, if available, offered in nontraditional settings that are accessible to families, diverse
6 communities and underserved populations.

7 (g) Each coordinated care organization uses health information technology to link services and
8 care providers across the continuum of care to the greatest extent practicable and if financially vi-
9 able.

10 (h) Each coordinated care organization complies with the safeguards for members described in
11 ORS 414.635.

12 (i) Each coordinated care organization convenes a community advisory council that meets the
13 criteria specified in ORS 414.627.

14 (j) Each coordinated care organization prioritizes working with members who have high health
15 care needs, multiple chronic conditions, mental illness or chemical dependency and involves those
16 members in accessing and managing appropriate preventive, health, remedial and supportive care
17 and services, including the services described in ORS 414.766, to reduce the use of avoidable emer-
18 gency room visits and hospital admissions.

19 (k) Members have a choice of providers within the coordinated care organization's network and
20 that providers participating in a coordinated care organization:

21 (A) Work together to develop best practices for care and service delivery to reduce waste and
22 improve the health and well-being of members.

23 (B) Are educated about the integrated approach and how to access and communicate within the
24 integrated system about a patient's treatment plan and health history.

25 (C) Emphasize prevention, healthy lifestyle choices, evidence-based practices, shared decision-
26 making and communication.

27 (D) Are permitted to participate in the networks of multiple coordinated care organizations.

28 (E) Include providers of specialty care.

29 (F) Are selected by coordinated care organizations using universal application and credentialing
30 procedures and objective quality information and are removed if the providers fail to meet objective
31 quality standards.

32 (G) Work together to develop best practices for culturally appropriate care and service delivery
33 to reduce waste, reduce health disparities and improve the health and well-being of members.

34 (L) Each coordinated care organization reports on outcome and quality measures adopted under
35 ORS 414.638 and participates in the health care data reporting system established in ORS 442.464
36 and 442.466.

37 (m) Each coordinated care organization uses best practices in the management of finances,
38 contracts, claims processing, payment functions and provider networks.

39 (n) Each coordinated care organization participates in the learning collaborative described in
40 ORS 413.259 (3).

41 (o) Each coordinated care organization has a governing body that complies with section 2,
42 chapter 49, Oregon Laws 2018, and that includes:

43 (A) At least one member representing persons that share in the financial risk of the organiza-
44 tion;

45 (B) A representative of a dental care organization selected by the coordinated care organization;

1 (C) The major components of the health care delivery system;

2 (D) At least two health care providers in active practice, including:

3 (i) A physician licensed under ORS chapter 677 or a nurse practitioner certified under ORS
4 678.375, whose area of practice is primary care; and

5 (ii) A mental health or chemical dependency treatment provider;

6 (E) At least two members from the community at large, to ensure that the organization's
7 decision-making is consistent with the values of the members and the community; and

8 (F) At least one member of the community advisory council.

9 (p) Each coordinated care organization's governing body establishes standards for publicizing
10 the activities of the coordinated care organization and the organization's community advisory
11 councils, as necessary, to keep the community informed.

12 (3) The authority shall consider the participation of area agencies and other nonprofit agencies
13 in the configuration of coordinated care organizations.

14 (4) In selecting one or more coordinated care organizations to serve a geographic area, the au-
15 thority shall:

16 (a) For members and potential members, optimize access to care and choice of providers;

17 (b) For providers, optimize choice in contracting with coordinated care organizations; and

18 (c) Allow more than one coordinated care organization to serve the geographic area if necessary
19 to optimize access and choice under this subsection.

20 (5) On or before July 1, 2014, each coordinated care organization must have a formal contractual
21 relationship with any dental care organization that serves members of the coordinated care organ-
22 ization in the area where they reside.

23 **SECTION 7.** ORS 414.635 is amended to read:

24 414.635. (1) The Oregon Health Authority shall adopt by rule safeguards for members enrolled
25 in coordinated care organizations that protect against underutilization of services and inappropriate
26 denials of services. **For behavioral health services, the standards must comply with the pro-
27 visions of sections 2 and 3 of this 2019 Act.** In addition to any other consumer rights and re-
28 sponsibilities established by law, each member:

29 (a) Must be encouraged to be an active partner in directing the member's health care and ser-
30 vices and not a passive recipient of care.

31 (b) Must be educated about the coordinated care approach being used in the community and how
32 to navigate the coordinated health care system.

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

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

40 (e) Shall be encouraged to work with the member's care team, including providers and commu-
41 nity resources appropriate to the member's needs as a whole person.

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

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

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

4 (3) Members and their providers and coordinated care organizations have the right to appeal
5 decisions about care and services through the authority in an expedited manner and in accordance
6 with the contested case procedures in ORS chapter 183.

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

10 (5) A health care entity may refuse to contract with a coordinated care organization if the re-
11 imbursement established for a service provided by the entity under the contract is below the rea-
12 sonable cost to the entity for providing the service.

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

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

17 (A) A health care entity’s refusal to contract with a coordinated care organization under sub-
18 sections (4) and (5) of this section.

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

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

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

25 (9) The authority shall:

26 (a) Monitor and enforce consumer rights and protections within the Oregon Integrated and Co-
27 ordinated Health Care Delivery System and ensure a consistent response to complaints of violations
28 of consumer rights or protections.

29 (b) Monitor and report on the statewide health care expenditures and recommend actions ap-
30 propriate and necessary to contain the growth in health care costs incurred by all sectors of the
31 system.

32 **SECTION 8.** ORS 414.766 is amended to read:

33 414.766. Notwithstanding ORS 414.065 and 414.690, a coordinated care organization must provide
34 behavioral health services to its members that include but are not limited to all of the following:

35 (1) For a member who is experiencing a behavioral health crisis, **who is hospitalized for a**
36 **behavioral health condition or who presents at an emergency department needing behavioral**
37 **health services:**

38 (a) A behavioral health assessment; and

39 (b) Services that are medically necessary to transition the member to a lower level of care;

40 (2) At least the minimum level of services that are medically necessary to treat a member’s be-
41 havioral health condition as determined in a behavioral health assessment of the member or speci-
42 fied in the member’s care plan; and

43 (3) Coordinated care and case management as defined by the Department of Consumer and
44 Business Services by rule.