SB 133-4
(LC 1399)
4/2/19 (SCT/ps)

Requested by SENATE COMMITTEE ON HEALTH CARE (at the request of Multnomah County)

PROPOSED AMENDMENTS TO
SENATE BILL 133

On page 1 of the printed bill, after "care;" delete the rest of the line and insert "creating new provisions; and amending ORS 414.065, 414.153 and 743A.168.".

Delete line 4 through 30 and delete page 2 and insert:

"SECTION 1. Section 2 of this 2019 Act is added to and made a part of ORS chapter 414.

"SECTION 2. The types and extent of health care and services to be provided in medical assistance, as determined by the Oregon Health Authority under ORS 414.065, must include crisis stabilization services, as described in ORS 430.630 (3)(b), and emergency services, as described in ORS 430.630 (2)(a), provided by community mental health programs.

"SECTION 3. ORS 414.065 is amended to read:

"414.065. (1)(a) With respect to health care and services to be provided in medical assistance during any period, the Oregon Health Authority shall determine, subject to such revisions as it may make from time to time and subject to legislative funding and paragraph (b) of this subsection:

"(A) The types and extent of health care and services to be provided to each eligible group of recipients of medical assistance.

"(B) Standards, including outcome and quality measures, to be observed in the provision of health care and services.

"(C) The number of days of health care and services toward the cost of

which medical assistance funds will be expended in the care of any person.

"(D) Reasonable fees, charges, daily rates and global payments for meeting the costs of providing health services to an applicant or recipient.

"(E) Reasonable fees for professional medical and dental services which may be based on usual and customary fees in the locality for similar services.

"(F) The amount and application of any copayment or other similar cost-sharing payment that the authority may require a recipient to pay toward the cost of health care or services.

"(b) The authority shall adopt rules establishing timelines for payment of health services under paragraph (a) of this subsection.

"**(c) The types and extent of health care and services to be provided in medical assistance, as determined by the authority under paragraph (a)(A) of this subsection, and the fees, charges, daily rates and global payments determined by the authority under paragraph (a)(D) and (E) of this subsection must be consistent with ORS 413.234, 414.153, 414.432, 414.653, 414.710, 414.712, 414.728, 414.743, 414.760, 414.762, 414.764, 414.766 and 414.770 and section 2 of this 2019 Act and any other provision of law requiring the authority or a coordinated care organization to reimburse the cost of a specific type of care for medical assistance recipients.**

"(2) The types and extent of health care and services and the amounts to be paid in meeting the costs thereof, as determined and fixed by the authority and within the limits of funds available therefor, shall be the total available for medical assistance and payments for such medical assistance shall be the total amounts from medical assistance funds available to providers of health care and services in meeting the costs thereof.

"(3) Except for payments under a cost-sharing plan, payments made by the authority for medical assistance shall constitute payment in full for all health care and services for which such payments of medical assistance were made.

"(4) Notwithstanding subsections (1) and (2) of this section, the Department of Human Services shall be responsible for determining the payment for Medicaid-funded long term care services and for contracting with the providers of long term care services.

"(5) In determining a global budget for a coordinated care organization:

"(a) The allocation of the payment, the risk and any cost savings shall be determined by the governing body of the organization;

"(b) The authority shall consider the community health assessment conducted by the organization and reviewed annually, and the organization's health care costs; and

"(c) The authority shall take into account the organization's provision of innovative, nontraditional health services.

"(6) Under the supervision of the Governor, the authority may work with the Centers for Medicare and Medicaid Services to develop, in addition to global budgets, payment streams:

"(a) To support improved delivery of health care to recipients of medical assistance; and

"(b) That are funded by coordinated care organizations, counties or other entities other than the state whose contributions qualify for federal matching funds under Title XIX or XXI of the Social Security Act.

"SECTION 4. ORS 414.153 is amended to read:

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

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

"(a) Immunizations;

"(b) Sexually transmitted diseases; and

"(c) Other communicable diseases;

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

"(a) Family planning services;

"(b) Human immunodeficiency virus and acquired immune deficiency syndrome prevention services; and

"(c) Maternity case management if the Oregon Health Authority determines that a coordinated care organization cannot adequately provide the services;

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

"(a) Maternity case management;

"(b) Well-child care;

"(c) Prenatal care;

"(d) School-based clinics;

"(e) Health care and services for children provided through schools and Head Start programs; and

"(f) Screening services to provide early detection of health care problems among low income women and children, migrant workers and other special population groups; and

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

"(a) May not prevent coordinated care organizations from contracting with other public or private providers for mental health or chemical de-

pendency services;

"(b) Must include agreed upon outcomes; and

"(c) Must describe the authorization and payments necessary to maintain the mental health safety net system and to maintain the efficient and effective management of the following responsibilities of local mental health authorities, with respect to the service needs of members of the coordinated care organization:

"(A) Management of children and adults at risk of entering or who are transitioning from the Oregon State Hospital or from residential care;

"(B) Care coordination of residential services and supports for adults and children;

"(C) Management of the mental health crisis system**, including the provision of crisis stabilization services, as described in ORS 430.630 (3)(b), and emergency services, as described in ORS 430.630 (2)(a)**;

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

"(E) Management of specialized services to reduce recidivism of individuals with mental illness in the criminal justice system.

"SECTION 5. ORS 743A.168 is amended to read:

"743A.168. (1) As used in this section:

"(a) 'Behavioral health assessment' means an evaluation by a provider, in person or using telemedicine, to determine a patient's need for behavioral health treatment.

"(b) 'Behavioral health crisis' means a disruption in an individual's mental or emotional stability or functioning resulting in an urgent need for immediate outpatient treatment in an emergency department or admission to a hospital to prevent a serious deterioration in the individual's mental or physical health.

"(c) 'Chemical dependency' means the addictive relationship with any drug or alcohol characterized by a physical or psychological relationship, or both, that interferes on a recurring basis with the individual's social, psychological or physical adjustment to common problems. For purposes of this section, 'chemical dependency' does not include addiction to, or dependency on, tobacco, tobacco products or foods.

"**(d) 'Crisis stabilization services' means the services described in ORS 430.630 (3)(b).**

"[*(d)*] **(e)** 'Facility' means a corporate or governmental entity or other provider of services for the treatment of chemical dependency or for the treatment of mental or nervous conditions.

"[*(e)*] **(f)** 'Group health insurer' means an insurer, a health maintenance organization or a health care service contractor.

"[*(f)*] **(g)** 'Program' means a particular type or level of service that is organizationally distinct within a facility.

"[*(g)*] **(h)** 'Provider' means:

"(A) An individual who has met the credentialing requirement of a group health insurer, is otherwise eligible to receive reimbursement for coverage under the policy and is a behavioral health professional or a medical professional licensed or certified in this state;

"(B) A health care facility as defined in ORS 433.060;

"(C) A residential facility as defined in ORS 430.010;

"(D) A day or partial hospitalization program;

"(E) An outpatient service as defined in ORS 430.010; [*or*]

"(F) A provider organization certified by the Oregon Health Authority under subsection (7) of this section[.]**; or**

"(G) A community mental health program.

"(2) A group health insurance policy providing coverage for hospital or medical expenses, other than limited benefit coverage, shall provide coverage for expenses arising from the diagnosis of and treatment for chemical de-

pendency, including alcoholism, and for mental or nervous conditions at the same level as, and subject to limitations no more restrictive than, those imposed on coverage or reimbursement of expenses arising from treatment for other medical conditions. The following apply to coverage for chemical dependency and for mental or nervous conditions:

"(a) The coverage may be made subject to provisions of the policy that apply to other benefits under the policy, including but not limited to provisions relating to deductibles and coinsurance. Deductibles and coinsurance for treatment in health care facilities or residential facilities may not be greater than those under the policy for expenses of hospitalization in the treatment of other medical conditions. Deductibles and coinsurance for outpatient treatment may not be greater than those under the policy for expenses of outpatient treatment of other medical conditions.

"(b) The coverage may not be made subject to treatment limitations, limits on total payments for treatment, limits on duration of treatment or financial requirements unless similar limitations or requirements are imposed on coverage of other medical conditions. The coverage of eligible expenses may be limited to treatment that is medically necessary as determined under the policy for other medical conditions.

"(c) The coverage must include:

"**(A) Crisis stabilization services;**

"[*(A)*] **(B)** A behavioral health assessment;

"[*(B)*] **(C)** No less than the level of services determined to be medically necessary in a behavioral health assessment of a patient or in a patient's care plan:

"(i) To treat the patient's behavioral health condition; and

"(ii) For care following a behavioral health crisis, to transition the patient to a lower level of care; and

"[*(C)*] **(D)** Coordinated care and case management as defined by the Department of Consumer and Business Services by rule.

"(d) A provider is eligible for reimbursement under this section if:

"(A) The provider is approved or certified by the Oregon Health Authority;

"(B) The provider is accredited for the particular level of care for which reimbursement is being requested by the Joint Commission or the Commission on Accreditation of Rehabilitation Facilities;

"(C) The patient is staying overnight at the facility and is involved in a structured program at least eight hours per day, five days per week; or

"(D) The provider is providing a covered benefit under the policy.

"(e) If specified in the policy, outpatient coverage may include follow-up in-home service or outpatient services. The policy may limit coverage for in-home service to persons who are homebound under the care of a physician.

"(f)(A) Subject to the patient or client confidentiality provisions of ORS 40.235 relating to physicians, ORS 40.240 relating to nurse practitioners, ORS 40.230 relating to psychologists, ORS 40.250 and 675.580 relating to licensed clinical social workers and ORS 40.262 relating to licensed professional counselors and licensed marriage and family therapists, a group health insurer may provide for review for level of treatment of admissions and continued stays for treatment in health facilities, residential facilities, day or partial hospitalization programs and outpatient services by either group health insurer staff or personnel under contract to the group health insurer, or by a utilization review contractor, who shall have the authority to certify for or deny level of payment.

"(B) Review shall be made according to criteria made available to providers in advance upon request.

"(C) Review shall be performed by or under the direction of a physician licensed under ORS 677.100 to 677.228, a psychologist licensed by the Oregon Board of Psychology, a clinical social worker licensed by the State Board of Licensed Social Workers or a professional counselor or marriage and family therapist licensed by the Oregon Board of Licensed Professional

Counselors and Therapists, in accordance with standards of the National Committee for Quality Assurance or Medicare review standards of the Centers for Medicare and Medicaid Services.

"(D) Review may involve prior approval, concurrent review of the continuation of treatment, post-treatment review or any combination of these. However, if prior approval is required, provision shall be made to allow for payment of urgent or emergency admissions, subject to subsequent review. If prior approval is not required, group health insurers shall permit providers, policyholders or persons acting on their behalf to make advance inquiries regarding the appropriateness of a particular admission to a treatment program. Group health insurers shall provide a timely response to such inquiries. Noncontracting providers must cooperate with these procedures to the same extent as contracting providers to be eligible for reimbursement.

"(g) Health maintenance organizations may limit the receipt of covered services by enrollees to services provided by or upon referral by providers contracting with the health maintenance organization. Health maintenance organizations and health care service contractors may create substantive plan benefit and reimbursement differentials at the same level as, and subject to limitations no more restrictive than, those imposed on coverage or reimbursement of expenses arising out of other medical conditions and apply them to contracting and noncontracting providers.

"(3) This section does not prohibit a group health insurer from managing the provision of benefits through common methods, including but not limited to selectively contracted panels, health plan benefit differential designs, preadmission screening, prior authorization of services, utilization review or other mechanisms designed to limit eligible expenses to those described in subsection (2)(b) of this section.

"(4) The Legislative Assembly finds that health care cost containment is necessary and intends to encourage health insurance plans designed to

achieve cost containment by ensuring that reimbursement is limited to appropriate utilization under criteria incorporated into the insurance, either directly or by reference.

"(5) This section does not prevent a group health insurer from contracting with providers of health care services to furnish services to policyholders or certificate holders according to ORS 743B.460 or 750.005, subject to the following conditions:

"(a) A group health insurer is not required to contract with all providers that are eligible for reimbursement under this section.

"(b) An insurer or health care service contractor shall, subject to subsection (2) of this section, pay benefits toward the covered charges of noncontracting providers of services for the treatment of chemical dependency or mental or nervous conditions. The insured shall, subject to subsection (2) of this section, have the right to use the services of a noncontracting provider of services for the treatment of chemical dependency or mental or nervous conditions, whether or not the services for chemical dependency or mental or nervous conditions are provided by contracting or noncontracting providers.

"(6)(a) This section does not require coverage for:

"(A) Educational or correctional services or sheltered living provided by a school or halfway house;

"(B) A long-term residential mental health program that lasts longer than 45 days;

"(C) Psychoanalysis or psychotherapy received as part of an educational or training program, regardless of diagnosis or symptoms that may be present;

"(D) A court-ordered sex offender treatment program; or

"(E) Support groups.

"(b) Notwithstanding paragraph (a)(A) of this subsection, an insured may receive covered outpatient services under the terms of the insured's policy

while the insured is living temporarily in a sheltered living situation.

"(7) The Oregon Health Authority shall establish a process for the certification of an organization described in subsection [*(1)(g)(F)*] **(1)(h)(F)** of this section that:

"(a) Is not otherwise subject to licensing or certification by the authority; and

"(b) Does not contract with the authority, a subcontractor of the authority or a community mental health program.

"(8) The Oregon Health Authority shall adopt by rule standards for the certification provided under subsection (7) of this section to ensure that a certified provider organization offers a distinct and specialized program for the treatment of mental or nervous conditions.

"(9) The Oregon Health Authority may adopt by rule an application fee or a certification fee, or both, to be imposed on any provider organization that applies for certification under subsection (7) of this section. Any fees collected shall be paid into the Oregon Health Authority Fund established in ORS 413.101 and shall be used only for carrying out the provisions of subsection (7) of this section.

"(10) The intent of the Legislative Assembly in adopting this section is to reserve benefits for different types of care to encourage cost effective care and to ensure continuing access to levels of care most appropriate for the insured's condition and progress. This section does not prohibit an insurer from requiring a provider organization certified by the Oregon Health Authority under subsection (7) of this section to meet the insurer's credentialing requirements as a condition of entering into a contract.

"(11) The Director of the Department of Consumer and Business Services and the Oregon Health Authority, after notice and hearing, may adopt reasonable rules not inconsistent with this section that are considered necessary for the proper administration of this section.

"SECTION 6. The amendments to ORS 743A.168 by section 5 of this

2019 Act apply to policies or certificates of health insurance issued, renewed or extended on or after the effective date of this 2019 Act.".
