SB 191 -1, -2 STAFF MEASURE SUMMARY

Senate Committee On Health Care

Prepared By: Daniel Dietz, LPRO Analyst
Meeting Dates: 2/6, 3/13

WHAT THE MEASURE DOES:

Requires Oregon Health Authority (OHA) to study fee-for-service medical assistance recipients' access to health care providers in rural areas of this state. Directs OHA to submit findings to interim committees of the Legislative Assembly not later than September 15, 2024. Sunsets January 2, 2025.

ISSUES DISCUSSED:

- Applicability to "open card" members of the Oregon Health Plan who are not assigned to a Coordinated Care Organization
- External review process administered by the Department of Consumer and Business Services

EFFECT OF AMENDMENT:

-1 Replaces the measure. Requires OHA to enter an interagency agreement with the Department of Consumer and Business Services (DCBS) to make independent medical review available to Oregon Health Plan (OHP) members when coordinated care organizations (CCOs) deny payment or coverage.

-2 Replaces the measure. Directs the Oregon Health Authority (OHA) to provide for external review, upon request from an enrollee, of an adverse benefit determination made by a coordinated care organization (CCO) or by OHA. Requires OHA to contract with independent review organizations to provide external review and for OHA to incur the cost of the review. Requires an enrollee to first complete the CCO internal appeal process or for open card enrollees, to file a grievance with OHA prior to requesting external review. Allows an enrollee to request a fair hearing following external review.

Defines "adverse benefit determination" as the denial, termination, or reduction of a health service, including denial of prior authorization. Requires the external review to be based on expert medical judgment and consideration of the enrollee's medical record, the recommendations of each of the enrollee's providers, medical standards, and cost-effectiveness. Prohibits review of determinations by the Health Evidence Review Commission (HERC) about placement of a condition or pairing of treatment on the prioritized list. Allows for review to determine whether a treatment affects a comorbid condition that is funded on the prioritized list.

Requires that enrollees be notified of the external review process upon receiving an adverse benefit determination. Establishes timeframes to request external review, for the review to be assigned to an independent review organization, for the CCO or OHA to provide materials, and for the independent review organization to complete its review. Requires expedited review in certain circumstances. Requires the CCO or OHA to comply with the determination of the independent review organization in a timely manner.

BACKGROUND:

External review is an independent medical review of a determination by a health plan or medical assistance program to deny, reduce, or terminate a health service. Under the Affordable Care Act, health plans are required to provide external review. State medical assistance programs have the option to provide them. Enrollees in the Oregon Health Plan do not have the option to request external review of a determination made by a Coordinated Care Organization (CCO) or, for open card enrollees, by the Oregon Health Authority (OHA).

In Oregon, if a CCO or OHA denies, reduces, or terminates a health service, the enrollee has sixty days to notify the CCO or OHA that they want to appeal the decision. The CCO or OHA then has sixteen days to respond. If the appeal is denied, a member can request an administrative fair hearing before an administrative law judge. In other states, including Texas and New York, enrollees in state assistance programs may request external review prior to an administrative fair hearing.

Senate Bill 1912 allows Oregon Health Plan enrollees to request external review of adverse benefit determinations made by Coordinated Care Organizations or by the Oregon Health Authority.