Chair Nosse, Co-Chairs and Members of the Committee,

My name is Heather Jefferis. I am testifying today on behalf Oregon Council for Behavioral Health. OCBH membership employs over ten thousand Oregonians statewide and serve hundreds of thousands of Oregonians annually. Today I ask for your support for HB 2463.

As a part of the reducing admisntrative burden and redundancy sub-committee, myself and my colleagues, including those testifying today, spent over a year of work deep diving in our deliberations of the numerous rules, reports and processes governing behavioral health. This included walk throughs of intake packets, analysis of current impacts of rule interpretations, and multiple partners reviewing compliance requirements. (Utilizing sub-committee created guiding principles. (attached page 2.))

Through this process we came to acknowledge a deep seed change was needed to achieve the vision of health equity and person-centered care. And it must begin with an overview of compliance requirements, rules, regulations, and the processes to actuate them. A process that helps achieve our state goal of equitable access to healthcare is the center, driving focus. However, years of layered administrative requirements have instead moved us further away from this goal. Particularly as the entire system struggles with a workforce crisis, with ever churning new staff and knowledge bases.

Here is one of the examples discovered in the work group that demonstrates the current discordant processes.

Prior to 2015 a piece of legislation resulted in ORS 430.637. This legislation and rule allowed OHA to create a process were the Certificate of Approval Audit could be shared and utilized by all CCO contractors reducing the amount of redundancy for providers and consumers. (pg. 3and 4)

The sub-committee membership realized it was never fully actuated; in fact some were unaware of its existence. This was a shocking missed opportunity. At some point after the rule, OHA created a data base to share audit information. Since then CCO's have been unable to access it and are not trained or aware, nor are most providers. The result is currently providers often experience between 4 and 7 full audits annually from a variety of parties in the system.

These audits are extremely time consuming, for all parties, including full reviews of charts, personnel records, billing records, interviews with staff, and interviews with consumers. Then each of these audits generate at least a handful of remediation / improvement activities that are frequently undone or interpreted differently by another auditor. This is extremely costly for all parties and disruptive for BH workforce and consumers.

This one example if, it had not been lost within the layers, could increase efficiency, reduce redundancy, improve moral, reduce consumer burden and save costs across the entire system for all involved.

Supporting HB 2463 will continue the work our subcommittee began. We've already submitted OAR revisions and made agency recommendations to the OHA and await their implementation. HB 2463 is an additional step to delve into statutory regulation as well as licensing, oversight, and support of a workforce based on modern behavioral healthcare delivery and equitable access to timely, quality care.

Heather Jefferis MA LARTT, Executive Director OCBH

Attached for committee member informational purposes.

1. Guiding principles

Administrative burden and redundancy reduction sub-committee guiding principles to address the work;

- Rules are a "living document" that require maintenance and updating.
- Aspirational goals do not belong in rule.
- Rules needs to be geo-agnostic.
- If a rule needs a variance out the gate, there's a problem with the rule.
- Rules need to address integrated care, SUD and mental health, IDD, ADP, BH in primary care, equity and episodic care.
- It is important that we vet our ideas and recommendations with others beyond this group, in particular frontline providers.
- Processes called for in the rules must be funded to function.
- Rules can't make it even harder for one provider type to do business; there shouldn't be different rule sets for different providers.
- If a provider is licensed and there is a licensing board, specification and oversight should not be in rule (i.e. nurse practitioners in 309)
- When updating OARs, changes need to be in the context of existing rule (309 & 410). Opt to update and change existing rules when possible; add language with restraint.
- If the rule goes beyond what is required federally, for private practice, or for non-BH providers, the question must be called of why?

A shared goal for Community Behavioral Health providers, CCOs, and the OHA is to ensure equitable access to behavioral health care. Transformation activities must be grounded in the goal of health equity. Addressing administrative burden enhances health equity by eliminating unnecessary barriers to care, decreasing public behavioral health workforce burnout, reducing overall system costs, and strengthening person-centered care of the system as both the BH workforce and consumer bear the burden of complying to rules that were created in a very different time.

2. Referenced in Testimony example.

430.278 Oregon Health Authority to evaluate rules governing behavioral health programs to reduce administrative burdens on providers. The Oregon Health Authority shall continually evaluate and revise administrative rules governing behavioral health programs and services to reduce the administrative burden of documentation, particularly around assessment and treatment planning, the measures and outcomes tracking system or successor systems and other reporting required for providers seeking certificates of approval and to ensure that the rules are consistent with the medical assistance program administrative rules that apply to behavioral health care staff operating in primary care and other settings. [2021 c.667 §6]

430.637 Criteria for certificate of approval issued to mental health or substance use disorder treatment provider; advisory committee; reporting requirements; rules. (1) As used in this section:

(a) "Assessment" means an on-site quality assessment of an organizational provider that is conducted:

(A) If the provider has not been accredited by a national organization meeting the quality standards of the Oregon Health Authority;

(B) By the Oregon Health Authority, another state agency or a contractor on behalf of the authority or another state agency; and

(C) For the purpose of issuing a certificate of approval.

(b) "Organizational provider" means an organization that provides mental health treatment or chemical dependency treatment and is not a coordinated care organization.

(2) The Oregon Health Authority shall convene a committee, in accordance with ORS 183.333, to advise the authority with respect to the adoption, by rule, of criteria for an assessment. The advisory committee shall advise the authority during the development of the criteria. The advisory committee shall be reconvened as needed to advise the authority with respect to updating the criteria to conform to changes in national accreditation standards or federal requirements for health plans and to advise the authority on opportunities to improve the assessment process. The advisory committee shall include, but is not limited to:

(a) A representative of each coordinated care organization certified by the authority;

(b) Representatives of organizational providers.

(c) Representatives of insurers and health care service contractors that have been accredited by the National Committee for Quality Assurance; and

(d) Representatives of insurers that offer Medicare Advantage Plans that have been accredited by the National Committee for Quality Assurance.

(3) The advisory committee described in subsection (2) of this section shall recommend:

(a) Objective criteria for a shared assessment tool that complies with national accreditation standards and federal requirements for health plans;

(b) Procedures for conducting an assessment.

(c) Procedures to eliminate redundant reporting requirements for organizational providers; and

(d) A process for addressing concerns that arise between assessments regarding compliance with quality standards.

(4) If another state agency, or a contractor on behalf of the state agency, conducts an assessment that meets the criteria adopted by the authority under subsection (2) of this section, the authority may rely on the assessment as evidence that the organizational provider meets the assessment requirement for receiving a certificate of approval.

(5) The authority shall provide a report of an assessment to the organizational provider that was assessed and, upon request, to a coordinated care organization, insurer, or health care service contractor.

(6) If an organizational provider has not been accredited by a national organization that is acceptable to a coordinated care organization, the coordinated care organization shall rely on the assessment conducted in accordance with the criteria adopted under subsection (2) of this section as evidence that the organizational provider meets the assessment requirement.

(7) This section does not:

(a) Prevent a coordinated care organization from requiring its own on-site quality assessment if the authority, another state agency or a contractor on behalf of the authority or another state agency has not conducted an assessment in the preceding 36-month period; or

(b) Require a coordinated care organization to contract with an organizational provider.

(8)(a) The authority shall adopt by rule standards for determining whether information requested by a coordinated care organization from an organizational provider is redundant with respect to the reporting requirements for an assessment or if the information is outside of the scope of the assessment criteria.

(b) A coordinated care organization may request additional information from an organizational provider, in addition to the report of the assessment, if the request:

(A) Is not redundant and is within the scope of the assessment according to standards adopted by the authority as described in this subsection; and

(B) Is necessary to resolve questions about whether an organizational provider meets the coordinated care organization's policies and procedures for credentialing.

(c) The authority shall implement a process for resolving a complaint by an organizational provider that a reporting requirement imposed by a coordinated care organization is redundant or outside of the scope of the assessment criteria.

(9)(a) The authority shall establish and maintain a database containing the documents required by coordinated care organizations for the purpose of credentialing an organizational provider.

(b) With the advice of the committee described in subsection (2) of this section, the authority shall adopt by rule the content and operational function of the database including, at a minimum:

(A) The types of organizational providers for which information is stored in the database;

(B) The types and contents of documents that are stored in the database;

(C) The frequency by which the documents the authority shall obtain updated documents;

(D) The means by which the authority will obtain the documents; and

(E) The means by which coordinated care organizations can access the documents in the database.

(c) The authority shall provide training to coordinated care organization staff who are responsible for processing credentialing requests on the use of the database. [2013 c.362 §1; 2015 c.152 §1]

Note: 430.637 and 430.638 were enacted into law by the Legislative Assembly but were not added to or made a part of ORS chapter 430 or any series therein by legislative action. See Preface to Oregon Revised Statutes for further explanation.