House Bill 3091

Sponsored by Representative KENY-GUYER, Senator GELSER, Representative GREENLICK; Representatives KOTEK, NOSSE, Senators BOQUIST, STEINER HAYWARD

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 specified facilities to provide certain case management and behavioral health services to individual who presents at facility experiencing behavioral health crisis.

Expands scope of emergency services that must be covered by health benefit plan to include treatment for behavioral health crisis.

Modifies entities eligible for insurance reimbursement for mental health and chemical dependency treatment.

A BILL FOR AN ACT

Relating to behavioral health treatment; creating new provisions; and amending ORS 743A.012 and 743A.168.

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

SECTION 1. (1) As used in this section:

(a) "Behavioral health" includes mental illness, substance use disorders and gambling disorders.

(b) "Behavioral health assessment" means a qualified mental health professional's determination of a patient's need for immediate crisis stabilization based upon an evaluation of the patient's strengths, goals, needs and current level of functioning.

(c) "Behavioral health crisis" means a disruption in an individual's mental or emotional stability or functioning resulting in an urgent need for immediate treatment to prevent a serious deterioration in the individual's mental or physical health that would require a significantly higher level of care.

(d) "Best practices risk assessment" means a methodology that:

(A) Uses guidelines or tools to determine a patient's level of risk for attempting or completing a self-inflicted injury or suicide;

(B) Is based on scientific research; and

(C) Uses best practices identified:

(i) In the Columbia-Suicide Severity Rating Scale;

(ii) In the Substance Abuse and Mental Health Services Administration National Registry of Evidence-based Programs and Practices; or

(iii) By the Suicide Prevention Resource Center.

(e) "Case management" means services provided to assist an individual who resides in a community setting or is moving to a community setting in accessing medical and behavioral health care, social and educational services, public assistance and medical assistance and other needed community services identified in the individual's plan for patient centered care.

(f) "Coordination of care" means the facilitation of ongoing communication and collab-

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.

oration by lay caregivers, community resource providers, health care providers and agencies to meet the multiple needs of a patient by:

(A) Organizing and participating in team meetings; and

(B) Ensuring continuity of care during each transition of care.

(g) "Crisis stabilization plan" means an individually tailored plan provided to a patient and the patient's lay caregiver that:

(A) Is based on the patient's behavioral health assessment and physical health assessment; and

(B) Describes the patient's specific short-term rehabilitation objectives and proposed crisis interventions.

(h) "Facility" means any of the following, as defined by the Oregon Health Authority by rule:

(A) If a patient is not subsequently admitted to a hospital for inpatient care:

(i) A mobile crisis service provider;

(ii) An emergency department; or

(iii) An urgent care clinic.

(B) A hospital.

(C) A subacute residential center.

(D) A behavioral crisis center.

(E) A psychiatric emergency services provider.

(i) "Lay caregiver" means:

(A) For a patient who is younger than 14 years of age, a parent or legal guardian of the patient.

(B) For a patient who is at least 14 years of age, an individual designated by the patient or a parent or legal guardian of the patient to the extent permitted under ORS 109.640 and 109.675.

(C) For a patient who is at least 14 years of age and who has not designated a caregiver, an individual to whom a health care provider may disclose protected health information without a signed authorization under ORS 192.567.

(j) "Lethal means counseling" means counseling strategies designed to reduce the access by a patient who is at risk for suicide to lethal means, including but not limited to firearms.

(k) "Medically appropriate treatment" means the services and supports necessary to diagnose, stabilize, care for and treat a behavioral health condition.

(L) "Mental status examination" means an overall assessment of a patient's mental health and level of functioning.

(m) "Patient centered care" means care provided in a manner that:

(A) Is respectful of and responsive to a patient's preferences, needs and values; and

(B) Ensures that all clinical decisions are guided by the patient's values.

(n) "Peer" means:

(A) An individual who is a current or former consumer of mental health treatment;

(B) An individual who is in recovery, as defined by the Oregon Health Authority by rule, from a substance use or gambling disorder; or

(C) A family member of a current or former consumer of behavioral health treatment.

(o) "Peer delivered services" means an array of services provided by agencies or community-based organizations to patients or family members of patients:

(A) Using peers or peer support specialists; and

(B) That are designed to support the needs of patients and their families.

(p) "Peer support specialist" means an individual who:

(A) Is providing peer delivered services to a patient;

(B) Has completed the peer support specialist training required by the Oregon Health Authority; and

(C) Is under the supervision of a qualified clinical supervisor.

(q) "Qualified mental health professional" means an individual meeting the minimum qualification criteria adopted by the Oregon Health Authority by rule for a qualified mental health professional.

(r) "Safety plan" means a written plan developed by a patient in collaboration with the patient's lay caregiver, if any, and the assistance of a health care provider that identifies strategies for the patient or lay caregiver to use when the patient's risk for suicide is elevated or following a suicide attempt.

(s) "Transition of care" means the process of transferring a patient from one provider or care setting to another provider or care setting.

(2) A facility shall provide coordination of care and case management services to a patient treated at the facility for a behavioral health crisis, including, at a minimum, all of the following:

(a) A behavioral health assessment or a mental status examination conducted by a qualified mental health professional.

(b) If indicated by a behavioral health assessment or mental status examination:

(A) A best practices risk assessment;

(B) A safety plan; or

(C) Lethal means counseling.

(c) A determination of the patient's clinical needs and recommendations, if within the scope of the provider's practice, for:

(A) Adjusting or prescribing medications;

(B) Therapeutic services;

(C) Medically appropriate treatment; or

(D) Peer delivered services.

(d) Recommendations as required or permitted under ORS 192.567, 441.196 and 441.198 to the patient, lay caregiver and health care provider.

(e) Informing the patient, lay caregiver and health care provider of the practitioners who can provide the recommended services and how to access the practitioners.

(f) Explaining to the patient and the lay caregiver crisis stabilization planning and patient centered care and establishing a goal of convening a care team.

(g) Designating a person to provide coordination of care who:

(A) Is part of a patient centered behavioral health home, as defined in ORS 414.025, a patient centered primary care home, as defined in ORS 414.025, or a patient centered medical home recognized by the National Committee for Quality Assurance;

(B) Is appropriately licensed;

(C) Will communicate directly with the patient and the lay caregiver; and

(D) When possible or requested, will meet personally with the patient and the lay caregiver.

(h) Creating with the patient and the lay caregiver a plan for the transition of care and sharing the plan with the patient's health care providers and care team.

(3) A facility that provides services to a patient experiencing a behavioral health crisis shall use communication technology that enables communication within and between emergency departments, primary care providers and medical homes.

SECTION 2. ORS 743A.012 is amended to read:

743A.012. (1) As used in this section:

(a) "Behavioral health assessment" has the meaning given that term in section 1 of this 2017 Act.

(b) "Behavioral health crisis" has the meaning given that term in section 1 of this 2017 Act.

(c) "Community mental health program" means the program described in ORS 430.620 (1)(b).

[*(a)*] **(d)** "Emergency medical condition" means [*a medical condition*]:

(A) **A medical condition** that manifests itself by acute symptoms of sufficient severity, including severe pain, that a prudent layperson possessing an average knowledge of health and medicine would reasonably expect that failure to receive immediate medical attention would:

(i) Place the health of a person, or an unborn child in the case of a pregnant woman, in serious jeopardy;

(ii) Result in serious impairment to bodily functions; or

(iii) Result in serious dysfunction of any bodily organ or part; [*or*]

(B) With respect to a pregnant woman who is having contractions, **a medical condition** for which there is inadequate time to effect a safe transfer to another hospital before delivery or for which a transfer may pose a threat to the health or safety of the woman or the unborn child**; or**

(C) A behavioral health crisis.

[*(b)*] **(e)** "Emergency medical screening exam" means the medical history, examination, ancillary tests and medical determinations required to ascertain the nature and extent of an emergency medical condition.

[*(c)*] **(f)** "Emergency services" means, with respect to an emergency medical condition:

(A) An emergency medical screening exam **or behavioral health assessment** that is within the capability of the emergency department of a hospital, **mobile crisis unit or community mental health program,** including ancillary services routinely available to the emergency department**, mobile crisis unit or community mental health program** to evaluate such emergency medical condition; [*and*]

(B) Such further medical examination and treatment as are required under 42 U.S.C. 1395dd to stabilize a patient, to the extent the examination and treatment are within the capability of the staff and facilities available at a hospital**; and**

(C) For a behavioral health crisis, services that are medically necessary to facilitate the patient's transition to a lower level of care as required by section 1 of this 2017 Act.

[*(d)*] **(g)** "Grandfathered health plan" has the meaning given that term in ORS 743B.005.

[*(e)*] **(h)** "Health benefit plan" has the meaning given that term in ORS 743B.005.

(i) "Mobile crisis unit" means a mobile crisis unit as defined by the Oregon Health Authority in accordance with section 1 of this 2017 Act.

[*(f)*] **(j)** "Prior authorization" has the meaning given that term in ORS 743B.001.

[*(g)*] **(k)** "Stabilize" means to provide medical treatment as necessary to:

(A) Ensure that, within reasonable medical probability, no material deterioration of an emergency medical condition is likely to occur during or to result from the transfer of the patient from a facility; and

(B) With respect to a pregnant woman who is in active labor, to perform the delivery, including the delivery of the placenta.

(2) All insurers offering a health benefit plan shall provide coverage without prior authorization for emergency services.

(3) A health benefit plan, other than a grandfathered health plan, must provide coverage required by subsection (2) of this section:

(a) For the services of participating providers, without regard to any term or condition of coverage other than:

(A) The coordination of benefits;

(B) An affiliation period or waiting period permitted under part 7 of the Employee Retirement Income Security Act, part A of Title XXVII of the Public Health Service Act or chapter 100 of the Internal Revenue Code;

(C) An exclusion other than an exclusion of emergency services; or

(D) Applicable cost-sharing; and

(b) For the services of a nonparticipating provider:

(A) Without imposing any administrative requirement or limitation on coverage that is more restrictive than requirements or limitations that apply to participating providers;

(B) Without imposing a copayment amount or coinsurance rate that exceeds the amount or rate for participating providers;

(C) Without imposing a deductible, unless the deductible applies generally to nonparticipating providers; and

(D) Subject only to an out-of-pocket maximum that applies to all services from nonparticipating providers.

(4) All insurers offering a health benefit plan shall provide information to enrollees in plain language regarding:

(a) What constitutes an emergency medical condition;

(b) The coverage provided for emergency services;

(c) How and where to obtain emergency services; and

(d) The appropriate use of 9-1-1.

(5) An insurer offering a health benefit plan may not discourage appropriate use of 9-1-1 and may not deny coverage for emergency services solely because 9-1-1 was used.

(6) This section is exempt from ORS 743A.001.

SECTION 3. ORS 743A.168, as amended by section 7, chapter 11, Oregon Laws 2016, is amended to read:

743A.168. A group health insurance policy providing coverage for hospital or medical expenses, other than limited benefit coverage, shall provide coverage for expenses arising from treatment for chemical dependency, 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:

(1) As used in this section:

(a) "Chemical dependency" means the addictive relationship with any drug or alcohol charac-

terized 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.

(b) "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.

(c) "Group health insurer" means an insurer, a health maintenance organization or a health care service contractor.

(d) "Program" means a particular type or level of service that is organizationally distinct within a facility.

(e) "Provider" means [*a person that*]:

(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;**

[*(i)*] **(B)** A health **care** facility as defined in ORS [*430.010*] **433.060**;

[*(ii)*] **(C)** A residential facility as defined in ORS 430.010;

[*(iii) A day or partial hospitalization program as defined in ORS 430.010;*]

[*(iv)*] **(D)** An outpatient service as defined in ORS 430.010; or

[*(v) An individual behavioral health or medical professional licensed or certified under Oregon law; or*]

[*(B)*] **(E)** [*Is*] A provider organization certified by the Oregon Health Authority under subsection (13) of this section.

(2) 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 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.

(3) 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.

(4)(a) Nothing in this section requires 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; or

(D) A court-ordered sex offender treatment program.

(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.

(5) 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 on Accreditation of Hospitals 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.

(6) Payments may not be made under this section for support groups.

(7) 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.

(8) Nothing in this section prohibits 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 (3) of this section.

(9) The Legislative Assembly has found that health care cost containment is necessary and intends to encourage insurance policies designed to achieve cost containment by ensuring that reimbursement is limited to appropriate utilization under criteria incorporated into such policies, either directly or by reference.

(10)(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 medical or osteopathic physician licensed by the Oregon Medical Board, a psychologist licensed by the State Board of Psychologist Examiners, 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.

(11) 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.

(12) Nothing in this section prevents 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 subsections (2) and (3) 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 subsections (2) and (3) 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.

(13) The Oregon Health Authority shall establish a process for the certification of an organization described in subsection [*(1)(e)(B)*] **(1)(e)(E)** 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.

(14) The Oregon Health Authority shall adopt by rule standards for the certification provided under subsection (13) of this section to ensure that a certified provider organization offers a distinct and specialized program for the treatment of mental or nervous conditions.

(15) 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 (13) 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 (13) of this section.

(16) 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 (13) of this section to meet the insurer's credentialing requirements as a condition of entering into a contract.

(17) 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.
