House Bill 4003

Sponsored by Representative NOSSE (Presession filed.)

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.** The statement includes a measure digest written in compliance with applicable readability standards.

Digest: The Act changes how OHA decides which health services are covered in the state Medicaid program. (Flesch Readability Score: 63.6).

Removes provisions relating to the use of the prioritized list of health services in the state medical assistance program. Requires the Oregon Health Authority to establish a definition of medical necessity and medical necessity criteria. Requires the Health Evidence Review Commission to develop and maintain clinical coverage policies that are consistent with the authority's definition of medical necessity and with federal laws governing mandatory and optional medical assistance services.

Declares an emergency, effective on passage.

A BILL FOR AN ACT

Relating to medical assistance; creating new provisions; amending ORS 414.025, 414.065, 414.325, 414.689, 414.690, 414.698, 414.701, 414.735, 414.780, 415.500 and 741.340; repealing ORS 414.694; and declaring an emergency.

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

SECTION 1. ORS 414.025 is amended to read:

414.025. As used in this chapter and ORS chapters 411 and 413, unless the context or a specially applicable statutory definition requires otherwise:

(1)(a) "Alternative payment methodology" means a payment other than a fee-for-services payment, used by coordinated care organizations as compensation for the provision of integrated and coordinated health care and services.

(b) "Alternative payment methodology" includes, but is not limited to:

(A) Shared savings arrangements;

(B) Bundled payments; and

(C) Payments based on episodes.

(2) "Behavioral health assessment" means an evaluation by a behavioral health clinician, in person or using telemedicine, to determine a patient's need for immediate crisis stabilization.

(3) "Behavioral health clinician" means:

(a) A licensed psychiatrist;

(b) A licensed psychologist;

(c) A licensed nurse practitioner with a specialty in psychiatric mental health;

(d) A licensed clinical social worker;

(e) A licensed professional counselor or licensed marriage and family therapist;

(f) A certified clinical social work associate;

(g) An intern or resident who is working under a board-approved supervisory contract in a clinical mental health field; or

(h) Any other clinician whose authorized scope of practice includes mental health diagnosis and

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.

treatment.

(4) "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.

(5) "Behavioral health home" means a mental health disorder or substance use disorder treatment organization, as defined by the Oregon Health Authority by rule, that provides integrated health care to individuals whose primary diagnoses are mental health disorders or substance use disorders.

(6) "Category of aid" means assistance provided by the Oregon Supplemental Income Program, aid granted under ORS 411.877 to 411.896 and 412.001 to 412.069 or federal Supplemental Security Income payments.

(7) "Community health worker" means an individual who meets qualification criteria adopted by the authority under ORS 414.665 and who:

(a) Has expertise or experience in public health;

(b) Works in an urban or rural community, either for pay or as a volunteer in association with a local health care system;

(c) To the extent practicable, shares ethnicity, language, socioeconomic status and life experiences with the residents of the community the worker serves;

(d) Assists members of the community to improve their health and increases the capacity of the community to meet the health care needs of its residents and achieve wellness;

(e) Provides health education and information that is culturally appropriate to the individuals being served;

(f) Assists community residents in receiving the care they need;

(g) May give peer counseling and guidance on health behaviors; and

(h) May provide direct services such as first aid or blood pressure screening.

(8) "Coordinated care organization" means an organization meeting criteria adopted by the Oregon Health Authority under ORS 414.572.

(9) "Dental subcontractor" means a prepaid managed care health services organization that enters into a noncomprehensive risk contract with a coordinated care organization or the Oregon Health Authority to provide dental services to medical assistance recipients.

(10) "Doula" means a trained professional who provides continuous physical, emotional and informational support to an individual during pregnancy, labor and delivery or the postpartum period to help the individual achieve the healthiest and most satisfying experience possible.

(11) "Dually eligible for Medicare and Medicaid" means, with respect to eligibility for enrollment in a coordinated care organization, that an individual is eligible for health services funded by Title XIX of the Social Security Act and is:

(a) Eligible for or enrolled in Part A of Title XVIII of the Social Security Act; or

(b) Enrolled in Part B of Title XVIII of the Social Security Act.

(12)(a) "Family support specialist" means an individual who meets qualification criteria adopted by the authority under ORS 414.665 and who provides supportive services to and has experience parenting a child who:

(A) Is a current or former consumer of mental health or addiction treatment; or

(B) Is facing or has faced difficulties in accessing education, health and wellness services due to a mental health or behavioral health barrier.

(b) A "family support specialist" may be a peer wellness specialist or a peer support specialist.

(13) "Global budget" means a total amount established prospectively by the Oregon Health Authority to be paid to a coordinated care organization for the delivery of, management of, access to and quality of the health care delivered to members of the coordinated care organization.

(14) "Health insurance exchange" or "exchange" means an American Health Benefit Exchange described in 42 U.S.C. 18031, 18032, 18033 and 18041.

(15) "Health services" means [*at least so much of*] each of the following [*as are*] **services, to the extent** funded by the Legislative Assembly [*based upon the prioritized list of health services compiled by the Health Evidence Review Commission under ORS 414.690*]:

(a) Services required by federal law to be included in the state's medical assistance program in order for the program to qualify for federal funds;

(b) Services provided by a physician as defined in ORS 677.010, a nurse practitioner licensed under ORS 678.375, a behavioral health clinician or other licensed practitioner within the scope of the practitioner's practice as defined by state law, and ambulance services;

(c) Prescription drugs;

(d) Laboratory and X-ray services;

(e) Medical equipment and supplies;

(f) Mental health services;

(g) Chemical dependency services;

(h) Emergency dental services;

(i) Nonemergency dental services;

(j) Provider services, other than services described in paragraphs (a) to (i), (k), (L) and (m) of this subsection, defined by federal law that may be included in the state's medical assistance program;

(k) Emergency hospital services;

(L) Outpatient hospital services; and

(m) Inpatient hospital services.

(16) "Income" has the meaning given that term in ORS 411.704.

(17)(a) "Integrated health care" means care provided to individuals and their families in a patient centered primary care home or behavioral health home by licensed primary care clinicians, behavioral health clinicians and other care team members, working together to address one or more of the following:

(A) Mental illness.

(B) Substance use disorders.

(C) Health behaviors that contribute to chronic illness.

(D) Life stressors and crises.

(E) Developmental risks and conditions.

(F) Stress-related physical symptoms.

(G) Preventive care.

(H) Ineffective patterns of health care utilization.

(b) As used in this subsection, "other care team members" includes but is not limited to:

(A) Qualified mental health professionals or qualified mental health associates meeting requirements adopted by the Oregon Health Authority by rule;

(B) Peer wellness specialists;

(C) Peer support specialists;

(D) Community health workers who have completed a state-certified training program;

(E) Personal health navigators; or

(F) Other qualified individuals approved by the Oregon Health Authority.

(18) "Investments and savings" means cash, securities as defined in ORS 59.015, negotiable instruments as defined in ORS 73.0104 and such similar investments or savings as the department or the authority may establish by rule that are available to the applicant or recipient to contribute toward meeting the needs of the applicant or recipient.

(19) "Medical assistance" means so much of the medical, mental health, preventive, supportive, palliative and remedial care and services as may be prescribed by the authority according to the standards established pursuant to ORS 414.065, including premium assistance under ORS 414.115 and 414.117, payments made for services provided under an insurance or other contractual arrangement and money paid directly to the recipient for the purchase of health services and for services described in ORS 414.710.

(20) "Medical assistance" includes any care or services for any individual who is a patient in a medical institution or any care or services for any individual who has attained 65 years of age or is under 22 years of age, and who is a patient in a private or public institution for mental diseases. Except as provided in ORS 411.439 and 411.447, "medical assistance" does not include care or services for a resident of a nonmedical public institution.

(21) "Mental health drug" means a type of legend drug, as defined in ORS 414.325, specified by the Oregon Health Authority by rule, including but not limited to:

(a) Therapeutic class 7 ataractics-tranquilizers; and

(b) Therapeutic class 11 psychostimulants-antidepressants.

(22) "Patient centered primary care home" means a health care team or clinic that is organized in accordance with the standards established by the Oregon Health Authority under ORS 414.655 and that incorporates the following core attributes:

(a) Access to care;

(b) Accountability to consumers and to the community;

(c) Comprehensive whole person care;

(d) Continuity of care;

(e) Coordination and integration of care; and

(f) Person and family centered care.

(23) "Peer support specialist" means any of the following individuals who meet qualification criteria adopted by the authority under ORS 414.665 and who provide supportive services to a current or former consumer of mental health or addiction treatment:

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

(b) An individual who is in recovery, as defined by the Oregon Health Authority by rule, from an addiction disorder.

(24) "Peer wellness specialist" means an individual who meets qualification criteria adopted by the authority under ORS 414.665 and who is responsible for assessing mental health and substance use disorder service and support needs of a member of a coordinated care organization through community outreach, assisting members with access to available services and resources, addressing barriers to services and providing education and information about available resources for individuals with mental health or substance use disorders in order to reduce stigma and discrimination toward consumers of mental health and substance use disorder services and to assist the member in creating and maintaining recovery, health and wellness.

(25) "Person centered care" means care that:

(a) Reflects the individual patient's strengths and preferences;

(b) Reflects the clinical needs of the patient as identified through an individualized assessment; and

(c) Is based upon the patient's goals and will assist the patient in achieving the goals.

(26) "Personal health navigator" means an individual who meets qualification criteria adopted by the authority under ORS 414.665 and who provides information, assistance, tools and support to enable a patient to make the best health care decisions in the patient's particular circumstances and in light of the patient's needs, lifestyle, combination of conditions and desired outcomes.

(27) "Prepaid managed care health services organization" means a managed dental care, mental health or chemical dependency organization that contracts with the authority under ORS 414.654 or with a coordinated care organization on a prepaid capitated basis to provide health services to medical assistance recipients.

(28) "Quality measure" means the health outcome and quality measures and benchmarks identified by the Health Plan Quality Metrics Committee and the metrics and scoring subcommittee in accordance with ORS 413.017 (4) and 413.022 and the quality metrics developed by the Behavioral Health Committee in accordance with ORS 413.017 (5).

(29)(a) "Quality of life in general measure" means an assessment of the value, effectiveness or cost-effectiveness of a treatment that gives greater value to a year of life lived in perfect health than the value given to a year of life lived in less than perfect health.

(b) "Quality of life in general measure" does not mean an assessment of the value, effectiveness or cost-effectiveness of a treatment during a clinical trial in which a study participant is asked to rate the participant's physical function, pain, general health, vitality, social functions or other similar domains.

(30) "Resources" has the meaning given that term in ORS 411.704. For eligibility purposes, "resources" does not include charitable contributions raised by a community to assist with medical expenses.

(31) "Social determinants of health" means:

(a) Nonmedical factors that influence health outcomes;

(b) The conditions in which individuals are born, grow, work, live and age; and

(c) The forces and systems that shape the conditions of daily life, such as economic policies and systems, development agendas, social norms, social policies, racism, climate change and political systems.

(32) "Tribal traditional health worker" means an individual who meets qualification criteria adopted by the authority under ORS 414.665 and who:

(a) Has expertise or experience in public health;

(b) Works in a tribal community or an urban Indian community, either for pay or as a volunteer in association with a local health care system;

(c) To the extent practicable, shares ethnicity, language, socioeconomic status and life experiences with the residents of the community the worker serves;

(d) Assists members of the community to improve their health, including physical, behavioral and oral health, and increases the capacity of the community to meet the health care needs of its residents and achieve wellness;

(e) Provides health education and information that is culturally appropriate to the individuals being served;

(f) Assists community residents in receiving the care they need;

(g) May give peer counseling and guidance on health behaviors; and

(h) May provide direct services, such as tribal-based practices.

(33)(a) "Youth support specialist" means an individual who meets qualification criteria adopted by the authority under ORS 414.665 and who, based on a similar life experience, provides supportive services to an individual who:

(A) Is not older than 30 years of age; and

(B)(i) Is a current or former consumer of mental health or addiction treatment; or

(ii) Is facing or has faced difficulties in accessing education, health and wellness services due to a mental health or behavioral health barrier.

(b) A "youth support specialist" may be a peer wellness specialist or a peer support specialist.

SECTION 2. ORS 414.065 is amended to read:

414.065. (1)(a) Consistent with ORS 414.690, 414.710, 414.712 and 414.766 and other statutes governing the provision of and payments for health services in medical assistance, the Oregon Health Authority shall [*determine*], subject to such revisions as it may make from time to time and to legislative funding:

(A) **Determine** the types and extent of health services to be provided to each eligible group of recipients of medical assistance **in accordance with federal laws governing mandatory and optional state medical assistance services**.

(B) **Establish by rule** standards, including **a definition of medical necessity, medical necessity criteria and** outcome and quality measures, to be observed in the provision of health services.

(C) **Determine** the number of days of health services toward the cost of which medical assistance funds will be expended in the care of any person.

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

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

(F) **Determine** 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 services.

(b) The authority shall adopt rules**:**

(A) Establishing timelines for payment of health services under paragraph (a) of this subsection.

(B) Defining the role of the clinical coverage policies developed under ORS 414.690 in determining the extent of health services to be provided to medical assistance recipients.

(C) Prescribing an appeal process for denials of coverage that allows for individual medical review.

(2) In [*making the determinations*] **performing the actions** under subsection (1) of this section and in the imposition of any utilization controls on access to health services, the authority may not consider a quality of life in general measure, either directly or by considering a source that relies on a quality of life in general measure.

(3) The types and extent of health 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 services in meeting the costs thereof.

(4) Except for payments under a cost-sharing plan, payments made by the authority for medical

assistance shall constitute payment in full for all health services for which such payments of medical assistance were made.

(5) Notwithstanding subsection (1) 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.

(6) 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 in accordance with ORS 414.577 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.

(7) 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 3. ORS 414.689 is amended to read:

414.689. (1) The Health Evidence Review Commission shall select one of its members as chairperson and another as vice chairperson, for terms and with duties and powers the commission determines necessary for the performance of the functions of the offices.

(2) A majority of the members of the commission constitutes a quorum for the transaction of business.

(3) The commission shall meet at least four times per year at a place, day and hour determined by the chairperson. The commission also shall meet at other times and places specified by the call of the chairperson or of a majority of the members of the commission. All meetings and deliberations of the commission shall be in accordance with ORS 192.610 to 192.690. The commission may not meet in executive session to hear evidence from an advisory committee or subcommittee or a panel of experts or to deliberate on matters presented by an advisory committee or subcommittee or a panel of experts.

(4) The commission may use advisory committees or subcommittees whose members are appointed by the chairperson of the commission subject to approval by a majority of the members of the commission. The advisory committees or subcommittees may contain experts appointed by the chairperson and a majority of the members of the commission. The conditions of service of the experts will be determined by the chairperson and a majority of the members of the commission.

(5) The Oregon Health Authority shall provide staff and support services to the commission.

(6) The commission shall adopt by rule practices to prevent undue influence by interested parties.

SECTION 4. ORS 414.690 is amended to read:

414.690. (1) The Health Evidence Review Commission shall regularly solicit testimony and information from [*stakeholders*] **interested parties** representing consumers, advocates, providers, carriers and employers in conducting the work of the commission.

(2) The commission shall actively solicit public involvement through a public meeting process

to guide health resource allocation decisions that includes, but is not limited to:

(a) Providing members of the public the opportunity to provide input on the selection of any vendor that provides research and analysis to the commission; and

(b) Inviting public comment on any research or analysis tool or health economic measures to be relied upon by the commission in the commission's decision-making.

(3)(a) The commission shall develop and maintain [*a list of health services ranked by priority, from the most important to the least important, representing the comparative benefits of each service to the population to be served*] **clinical coverage policies that include:**

(A) Diagnosis and treatment code pairings that indicate which health services are medically necessary for which conditions; and

(B) Coverage guidelines regarding medically necessary health services.

(b) The clinical coverage policies developed under this section must be consistent with the medical necessity definition established by the Oregon Health Authority under ORS 414.065 and federal laws governing mandatory and optional state medical assistance services.

[*(b)*] **(c)** Except as provided in ORS 414.701, the commission may not rely upon any quality of life in general measures, either directly or by considering research or analysis that relies on a quality of life in general measure, in determining:

(A) Whether a service is cost-effective;

(B) Whether a service is recommended; or

(C) The value of a service.

[*(c)*] **(d)** The [*list*] **clinical coverage policies developed under this section** must be submitted by the commission pursuant to subsection (5) of this section and [*is*] **are** not subject to alteration by any other state agency.

(4) In order to encourage effective and efficient medical evaluation and treatment, the commission:

(a) [*May include clinical practice guidelines in its prioritized list of services. The commission*] Shall actively solicit testimony and information from the medical community and the public to build a consensus on clinical [*practice guidelines*] **coverage policies** developed by the commission.

(b) May include statements of intent in its [*prioritized list of services*] **clinical coverage policies**. Statements of intent should give direction on coverage decisions where medical codes and [*clinical practice*] **coverage** guidelines cannot convey the intent of the commission.

(c) Shall consider both the clinical effectiveness and cost-effectiveness**, according to peer-reviewed medical literature,** of health services, including drug therapies, in [*determining their relative importance using peer-reviewed medical literature*] **developing clinical coverage policies**.

(5) The commission shall report [*the prioritized list of services*] **any changes to the clinical coverage policies developed under this section** to the Oregon Health Authority for budget determinations by July 1 of each even-numbered year.

(6) The commission shall make its report during each regular session of the Legislative Assembly and shall submit a copy of its report to the Governor, the Speaker of the House of Representatives and the President of the Senate and post to the Oregon Health Authority's website, along with a solicitation of public comment, an assessment of the impact on access to medically necessary treatment and services by persons with disabilities or chronic illnesses resulting from the commission's prior use of any quality of life in general measures or any research or analysis that referred to or relied upon a quality of life in general measure.

(7) The commission may alter the [*list*] **clinical coverage policies developed under this section** during the interim only as follows:

(a) To make technical changes to correct errors and omissions;

(b) To accommodate changes due to advancements in medical technology or new data regarding health outcomes;

(c) To accommodate changes to [*clinical practice*] **coverage** guidelines; and

(d) To add **or modify** statements of intent that clarify the [*prioritized list*] **commission's clinical coverage policies**.

[*(8) If a service is deleted or added during an interim and no new funding is required, the commission shall report to the Speaker of the House of Representatives and the President of the Senate. However, if a service to be added requires increased funding to avoid discontinuing another service, the commission shall report to the Emergency Board to request the funding.*]

(8) If the commission changes the clinical coverage policies developed under this section during an interim, the commission shall report the change to the authority. If the change requires increased funding, the authority may request additional funding from the Emergency Board.

(9) [*The prioritized list of services remains*] **Changes to the clinical coverage policies developed under this section, as reported under subsection (5) of this section, shall remain** in effect for a two-year period beginning no earlier than October 1 of each odd-numbered year.

(10)(a) As used in this section, "peer-reviewed medical literature" means scientific studies printed in journals or other publications that publish original manuscripts only after the manuscripts have been critically reviewed by unbiased independent experts for scientific accuracy, validity and reliability.

(b) "Peer-reviewed medical literature" does not include internal publications of pharmaceutical manufacturers.

SECTION 5. ORS 414.701 is amended to read:

414.701. (1) As used in this section, "peer-reviewed medical literature" has the meaning given that term in ORS 414.690.

(2) The Health Evidence Review Commission, in [*ranking health services or developing guidelines*] **developing clinical coverage policies** under ORS 414.690 or in assessing medical technologies under ORS 414.698, and the Pharmacy and Therapeutics Committee, in considering a recommendation for a drug to be included on any preferred drug list or on the Practitioner-Managed Prescription Drug Plan:

(a) May not rely solely on the results of comparative effectiveness research but must evaluate a range of research and analysis, including peer-reviewed medical literature that:

(A) Studies health outcomes that are priorities for persons with disabilities who experience specific diseases or illnesses, through surveys or other methods of identifying priority outcomes for individuals who experience the diseases or illnesses;

(B) Studies subgroups of patients who experience specific diseases or illnesses, to ensure consideration of any important differences and clinical characteristics applicable to the subgroups; and

(C) Considers the full range of relevant, peer-reviewed medical literature and avoids harm to patients caused by undue emphasis on evidence that is deemed inconclusive of clinical differences without further investigation.

(b) May consider research or analyses that reference a quality of life in general measure only if:

(A) The staff of the commission includes an individual who:

(i) Is trained in identifying bias and discrimination in medical research and analyses;

(ii) Is not involved in research evaluation and recommendations for a given condition-treatment pair on the prioritized list subject to the commission's review; and

(iii) Determines that any of a researcher's conclusions and analyses about the value or cost-effectiveness of a treatment, that were relied upon by the staff of the commission in making a recommendation regarding the treatment, did not rely upon and were not influenced by the quality of life in general measure; and

(B) All references to the quality of life in general measure are redacted from the research or analyses before the research or analyses are presented to the commission or to any advisory committee or subcommittees used or consulted by the commission.

(3) The commission may not contract with a single vendor to provide or compile research and analysis that is considered by the commission, and the commission shall publicly disclose, regarding vendors providing or compiling research or analysis to the commission:

(a) The vendors' funding sources; and

(b) Any conflicts of interest that a vendor may have with respect to the research and analysis provided.

SECTION 6. ORS 414.735 is amended to read:

414.735. (1) If insufficient resources are available during a contract period:

(a) The population of eligible persons determined by law may not be reduced.

(b) The reimbursement rate for providers and plans established under the contractual agreement may not be reduced.

(2) In the circumstances described in subsection (1) of this section, reimbursement [*shall*] **may** be adjusted by reducing the health services for the eligible population [*by eliminating services in the order of priority recommended by the Health Evidence Review Commission, starting with the least important and progressing toward the most important*]. **The Oregon Health Authority shall consult with the Health Evidence Review Commission before implementing a significant reduction in health services.**

(3) The [*Oregon Health*] authority shall obtain the approval of the Legislative Assembly, or the Emergency Board if the Legislative Assembly is not in session, before instituting the reductions. In addition, providers contracting to provide health services under [*ORS 414.591, 414.631 and 414.688 to 414.745*] **this chapter** must be notified at least two weeks prior to any legislative consideration of such reductions. Any reductions made under this section shall take effect no sooner than 60 days following final legislative action approving the reductions.

(4) This section does not apply to reductions made by the Legislative Assembly in a legislatively adopted or approved budget.

SECTION 7. ORS 414.325 is amended to read:

414.325. (1) As used in this section:

(a) "Legend drug" means any drug requiring a prescription by a practitioner, as defined in ORS 689.005.

(b) "Urgent medical condition" means a medical condition that arises suddenly, is not life-threatening and requires prompt treatment to avoid the development of more serious medical problems.

(2) A licensed practitioner may prescribe such drugs under this chapter as the practitioner in the exercise of professional judgment considers appropriate for the diagnosis or treatment of the

patient in the practitioner's care and within the scope of practice. Prescriptions shall be dispensed in the generic form pursuant to ORS 689.515 and pursuant to rules of the Oregon Health Authority unless the practitioner prescribes otherwise and an exception is granted by the authority.

(3) Except as provided in subsections (4) and (5) of this section, the authority shall place no limit on the type of legend drug that may be prescribed by a practitioner, but the authority shall pay only for drugs in the generic form unless an exception has been granted by the authority.

(4) Notwithstanding subsection (3) of this section, an exception must be applied for and granted before the authority is required to pay for minor tranquilizers and amphetamines and amphetamine derivatives, as defined by rule of the authority.

(5)(a) Notwithstanding subsections (1) to (4) of this section and except as provided in paragraph (b) of this subsection, the authority is authorized to:

(A) Withhold payment for a legend drug when federal financial participation is not available; and

(B) Require prior authorization of payment for drugs that the authority has determined should be limited to those conditions generally recognized as appropriate by the medical profession.

(b) The authority may not require prior authorization for:

(A) Therapeutic classes of nonsedating antihistamines and nasal inhalers, as defined by rule by the authority, when prescribed by an allergist for treatment of any of the following conditions, as described by the Health Evidence Review Commission [*on the funded portion of its prioritized list of services*] **in the clinical coverage policies developed under ORS 414.690**:

(i) Asthma;

(ii) Sinusitis;

(iii) Rhinitis; or

(iv) Allergies.

(B) Any mental health drug prescribed for a medical assistance recipient if:

(i) The claims history available to the authority shows that the recipient has been in a course of treatment with the drug during the preceding 365-day period; or

(ii) The prescriber specifies on the prescription "dispense as written" or includes the notation "D.A.W." or words of similar meaning.

(6) The authority shall pay a rural health clinic for a legend drug prescribed and dispensed under this chapter by a licensed practitioner at the rural health clinic for an urgent medical condition if:

(a) There is not a pharmacy within 15 miles of the clinic;

(b) The prescription is dispensed for a patient outside of the normal business hours of any pharmacy within 15 miles of the clinic; or

(c) No pharmacy within 15 miles of the clinic dispenses legend drugs under this chapter.

(7) Notwithstanding ORS 414.334, the authority may conduct prospective drug utilization review in accordance with ORS 414.351 to 414.414.

(8) Notwithstanding subsection (3) of this section, the authority may pay a pharmacy for a particular brand name drug rather than the generic version of the drug after notifying the pharmacy that the cost of the particular brand name drug, after receiving discounted prices and rebates, is equal to or less than the cost of the generic version of the drug.

(9)(a) Within 180 days after the United States patent expires on an immunosuppressant drug used in connection with an organ transplant, the authority shall determine whether the drug is a narrow therapeutic index drug.

(b) As used in this subsection, "narrow therapeutic index drug" means a drug that has a narrow range in blood concentrations between efficacy and toxicity and requires therapeutic drug concentration or pharmacodynamic monitoring.

SECTION 8. ORS 414.698 is amended to read:

414.698. (1) The Health Evidence Review Commission shall conduct comparative effectiveness research of medical technologies selected in accordance with ORS 414.695. The commission may conduct the research by comprehensive review of the comparative effectiveness research undertaken by recognized state, national or international entities. The commission may consider evidence relating to prescription drugs that is relevant to a medical technology assessment but may not conduct a drug class evidence review or medical technology assessment solely of a prescription drug. The commission shall disseminate the research findings to health care consumers, providers and third-party payers and to other interested [*stakeholders*] **parties**.

(2) The commission shall develop or identify and shall disseminate evidence-based health care guidelines for use by providers, consumers and purchasers of health care in Oregon.

(3) The Oregon Health Authority shall vigorously pursue health care purchasing strategies that adopt the research findings described in subsection (1) of this section and the evidence-based health care guidelines described in subsection (2) of this section.

SECTION 9. ORS 414.780 is amended to read:

414.780. (1) As used in this section:

(a) "Behavioral health coverage" means mental health treatment and services and substance use disorder treatment or services reimbursed by a coordinated care organization.

(b) "Coordinated care organization" has the meaning given that term in ORS 414.025.

(c) "Mental health treatment and services" means the treatment of or services provided to address any condition or disorder that falls under any of the diagnostic categories listed in the mental disorders section of the current edition of the:

(A) International Classification of Disease; or

(B) Diagnostic and Statistical Manual of Mental Disorders.

(d) "Nonquantitative treatment limitation" means a limitation that is not expressed numerically but otherwise limits the scope or duration of behavioral health coverage, such as medical necessity criteria or other utilization review.

(e) "Substance use disorder treatment and services" means the treatment of and any services provided to address any condition or disorder that falls under any of the diagnostic categories listed in the substance use section of the current edition of the:

(A) International Classification of Disease; or

(B) Diagnostic and Statistical Manual of Mental Disorders.

(2) No later than March 1 of each calendar year, the Oregon Health Authority shall prescribe the form and manner for each coordinated care organization to report to the authority, on or before June 1 of the calendar year, information about the coordinated care organization's compliance with mental health parity requirements, including but not limited to the following:

(a) The specific plan or coverage terms or other relevant terms regarding the nonquantitative treatment limitations and a description of all mental health or substance use disorder benefits and medical or surgical benefits to which each such term applies in each respective benefits classification.

(b) The factors used to determine that the nonquantitative treatment limitations will apply to mental health or substance use disorder benefits and medical or surgical benefits.

(c) The evidentiary standards used for the factors identified in paragraph (b) of this subsection, when applicable, provided that every factor is defined, and any other source or evidence relied upon to design and apply the nonquantitative treatment limitations to mental health or substance use disorder benefits and medical or surgical benefits.

(d) The number of denials of coverage of mental health treatment and services, substance use disorder treatment and services and medical and surgical treatment and services, the percentage of denials that were appealed, the percentage of appeals that upheld the denial and the percentage of appeals that overturned the denial.

(e) The percentage of claims for behavioral health coverage and for coverage of medical and surgical treatments that were paid to in-network providers and the percentage of such claims that were paid to out-of-network providers.

(f) Other data or information the authority deems necessary to assess a coordinated care organization's compliance with mental health parity requirements.

(3) Coordinated care organizations must demonstrate in the documentation submitted under subsection (2) of this section, that the processes, strategies, evidentiary standards and other factors used to apply nonquantitative treatment limitation to mental health or substance use disorder treatment, as written and in operation, are comparable to and are applied no more stringently that the processes, strategies, evidentiary standards and other factors used to apply nonquantitative treatment limitations to medical or surgical treatments in the same classification.

(4) Each calendar year the authority, in collaboration with individuals representing behavioral health treatment providers, community mental health programs, coordinated care organizations, the Consumer Advisory Council established in ORS 430.073 and consumers of mental health or substance use disorder treatment, shall, based on the information reported under subsection (2) of this section, identify and assess:

(a) Coordinated care organizations' compliance with the requirements for parity between the behavioral health coverage and the coverage of medical and surgical treatment in the medical assistance program; and

(b) The authority's compliance with the requirements for parity between the behavioral health coverage and the coverage of medical and surgical treatment in the medical assistance program for individuals who are not enrolled in a coordinated care organization.

(5) No later than December 31 of each calendar year, the authority shall submit a report to the interim committees of the Legislative Assembly related to mental or behavioral health, in the manner provided in ORS 192.245, that includes:

(a) The authority's findings under subsection (4) of this section on compliance with rules regarding mental health parity, including a comparison of coverage for members of coordinated care organizations to coverage for medical assistance recipients who are not enrolled in coordinated care organizations as applicable; and

(b) An assessment of:

(A) The adequacy of the provider network as prescribed by the authority by rule.

(B) The timeliness of access to mental health and substance use disorder treatment and services, as prescribed by the authority by rule.

(C) The criteria used by each coordinated care organization to determine medical necessity and behavioral health coverage, including each coordinated care organization's payment protocols and procedures.

(D) Data on services that are requested but that coordinated care organizations are not required

to provide.

(E) The consistency of credentialing requirements for behavioral health treatment providers with the credentialing of medical and surgical treatment providers.

(F) The utilization review, as defined by the authority by rule, applied to behavioral health coverage compared to coverage of medical and surgical treatments.

(G) The specific findings and conclusions reached by the authority with respect to the coverage of mental health and substance use disorder treatment and the authority's analysis that indicates that the coverage is or is not in compliance with this section.

(H) The specific findings and conclusions of the authority demonstrating a coordinated care organization's compliance with this section and with the Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008 (P.L. 110-343) and rules adopted thereunder.

(6) Except as provided in subsection (5)(b)(D) of this section, this section does not require coordinated care organizations to report data on services that are not [*funded on the prioritized list of health services compiled by the Health Evidence Review Commission under ORS 414.690*] **covered health services under the state medical assistance program, as determined under ORS 414.065 and 414.690**.

SECTION 10. ORS 415.500 is amended to read:

415.500. As used in this section and ORS 415.501 and 415.505:

(1) "Corporate affiliation" has the meaning prescribed by the Oregon Health Authority by rule, including:

(a) Any relationship between two organizations that reflects, directly or indirectly, a partial or complete controlling interest or partial or complete corporate control; and

(b) Transactions that merge tax identification numbers or corporate governance.

(2) "Essential services" means:

(a) Services that are [*funded on the prioritized list described in ORS 414.690*] **covered under the state medical assistance program, as determined under ORS 414.065 and 414.690**; and

(b) Services that are essential to achieve health equity.

(3) "Health benefit plan" has the meaning given that term in ORS 743B.005.

(4)(a) "Health care entity" includes:

(A) An individual health professional licensed or certified in this state;

(B) A hospital, as defined in ORS 442.015, or hospital system, as defined by the authority by rule;

(C) A carrier, as defined in ORS 743B.005, that offers a health benefit plan in this state;

(D) A Medicare Advantage plan;

(E) A coordinated care organization or a prepaid managed care health services organization, as both terms are defined in ORS 414.025; and

(F) Any other entity that has as a primary function the provision of health care items or services or that is a parent organization of, or is an entity closely related to, an entity that has as a primary function the provision of health care items or services.

(b) "Health care entity" does not include:

(A) Long term care facilities, as defined in ORS 442.015.

(B) Facilities licensed and operated under ORS 443.400 to 443.455.

(5) "Health equity" has the meaning prescribed by the Oregon Health Policy Board and adopted by the authority by rule.

(6)(a) "Material change transaction" means:

(A) A transaction in which at least one party had average revenue of $25 million or more in the

preceding three fiscal years and another party:

(i) Had an average revenue of at least $10 million in the preceding three fiscal years; or

(ii) In the case of a new entity, is projected to have at least $10 million in revenue in the first full year of operation at normal levels of utilization or operation as prescribed by the authority by rule.

(B) If a transaction involves a health care entity in this state and an out-of-state entity, a transaction that otherwise qualifies as a material change transaction under this paragraph that may result in increases in the price of health care or limit access to health care services in this state.

(b) "Material change transaction" does not include:

(A) A clinical affiliation of health care entities formed for the purpose of collaborating on clinical trials or graduate medical education programs.

(B) A medical services contract or an extension of a medical services contract.

(C) An affiliation that:

(i) Does not impact the corporate leadership, governance or control of an entity; and

(ii) Is necessary, as prescribed by the authority by rule, to adopt advanced value-based payment methodologies to meet the health care cost growth targets under ORS 442.386.

(D) Contracts under which one health care entity, for and on behalf of a second health care entity, provides patient care and services or provides administrative services relating to, supporting or facilitating the provision of patient care and services, if the second health care entity:

(i) Maintains responsibility, oversight and control over the patient care and services; and

(ii) Bills and receives reimbursement for the patient care and services.

(E) Transactions in which a participant that is a health center as defined in 42 U.S.C. 254b, while meeting all of the participant's obligations, acquires, affiliates with, partners with or enters into any agreement with another entity unless the transaction would result in the participant no longer qualifying as a health center under 42 U.S.C. 254b.

(7)(a) "Medical services contract" means a contract to provide medical or mental health services entered into by:

(A) A carrier and an independent practice association;

(B) A carrier, coordinated care organization, independent practice association or network of providers and one or more providers, as defined in ORS 743B.001;

(C) An independent practice association and an individual health professional or an organization of health care providers;

(D) Medical, dental, vision or mental health clinics; or

(E) A medical, dental, vision or mental health clinic and an individual health professional to provide medical, dental, vision or mental health services.

(b) "Medical services contract" does not include a contract of employment or a contract creating a legal entity and ownership of the legal entity that is authorized under ORS chapter 58, 60 or 70 or under any other law authorizing the creation of a professional organization similar to those authorized by ORS chapter 58, 60 or 70, as may be prescribed by the authority by rule.

(8) "Net patient revenue" means the total amount of revenue, after allowance for contractual amounts, charity care and bad debt, received for patient care and services, including:

(a) Value-based payments;

(b) Incentive payments;

(c) Capitation payments or payments under any similar contractual arrangement for the prepayment or reimbursement of patient care and services; and

(d) Any payment received by a hospital to reimburse a hospital assessment under ORS 414.855.

(9) "Revenue" means:

(a) Net patient revenue; or

(b) The gross amount of premiums received by a health care entity that are derived from health benefit plans.

(10) "Transaction" means:

(a) A merger of a health care entity with another entity;

(b) An acquisition of one or more health care entities by another entity;

(c) New contracts, new clinical affiliations and new contracting affiliations that will eliminate or significantly reduce, as defined by the authority by rule, essential services;

(d) A corporate affiliation involving at least one health care entity; or

(e) Transactions to form a new partnership, joint venture, accountable care organization, parent organization or management services organization, as prescribed by the authority by rule.

SECTION 11. ORS 415.500, as amended by section 21, chapter 4, Oregon Laws 2025, is amended to read:

415.500. As used in this section and ORS 415.501 and 415.505:

(1) "Corporate affiliation" has the meaning prescribed by the Oregon Health Authority by rule, including:

(a) Any relationship between two organizations that reflects, directly or indirectly, a partial or complete controlling interest or partial or complete corporate control; and

(b) Transactions that merge tax identification numbers or corporate governance.

(2) "Essential services" means:

(a) Services that are [*funded on the prioritized list described in ORS 414.690*] **covered under the state medical assistance program, as determined under ORS 414.065 and 414.690**; and

(b) Services that are essential to achieve health equity.

(3) "Health benefit plan" has the meaning given that term in ORS 743B.005.

(4)(a) "Health care entity" includes:

(A) An individual health professional licensed or certified in this state;

(B) A hospital, as defined in ORS 442.015, or hospital system, as defined by the authority by rule;

(C) A carrier, as defined in ORS 743B.005, that offers a health benefit plan in this state;

(D) A Medicare Advantage plan;

(E) A coordinated care organization or a prepaid managed care health services organization, as both terms are defined in ORS 414.025; and

(F) Any other entity that has as a primary function the provision of health care items or services or that is a parent organization of, or is an entity closely related to, an entity that has as a primary function the provision of health care items or services.

(b) "Health care entity" does not include:

(A) Long term care facilities, as defined in ORS 442.015.

(B) Facilities licensed and operated under ORS 443.400 to 443.455.

(5) "Health equity" has the meaning prescribed by the Oregon Health Policy Board and adopted by the authority by rule.

(6)(a) "Material change transaction" means:

(A) A transaction in which at least one party had average revenue of $25 million or more in the preceding three fiscal years and another party:

(i) Had an average revenue of at least $10 million in the preceding three fiscal years; or

(ii) In the case of a new entity, is projected to have at least $10 million in revenue in the first full year of operation at normal levels of utilization or operation as prescribed by the authority by rule.

(B) If a transaction involves a health care entity in this state and an out-of-state entity, a transaction that otherwise qualifies as a material change transaction under this paragraph that may result in increases in the price of health care or limit access to health care services in this state.

(b) "Material change transaction" does not include:

(A) A clinical affiliation of health care entities formed for the purpose of collaborating on clinical trials or graduate medical education programs.

(B) A medical services contract or an extension of a medical services contract.

(C) An affiliation that:

(i) Does not impact the corporate leadership, governance or control of an entity; and

(ii) Is necessary, as prescribed by the authority by rule, to adopt advanced value-based payment methodologies to meet the health care cost growth targets under ORS 442.386.

(D) Contracts under which one health care entity, for and on behalf of a second health care entity, provides patient care and services or provides administrative services relating to, supporting or facilitating the provision of patient care and services, if the second health care entity:

(i) Maintains responsibility, oversight and control over the patient care and services; and

(ii) Bills and receives reimbursement for the patient care and services.

(E) Transactions in which a participant that is a health center as defined in 42 U.S.C. 254b, while meeting all of the participant's obligations, acquires, affiliates with, partners with or enters into any agreement with another entity unless the transaction would result in the participant no longer qualifying as a health center under 42 U.S.C. 254b.

(7)(a) "Medical services contract" means a contract to provide medical or mental health services entered into by:

(A) A carrier and an independent practice association;

(B) A carrier, coordinated care organization, independent practice association or network of providers and one or more providers, as defined in ORS 743B.001;

(C) An independent practice association and an individual health professional or an organization of health care providers;

(D) Medical, dental, vision or mental health clinics; or

(E) A medical, dental, vision or mental health clinic and an individual health professional to provide medical, dental, vision or mental health services.

(b) "Medical services contract" does not include a contract of employment or a contract creating a legal entity and ownership of the legal entity that is authorized under ORS chapter 58, 60 or 70 or under any other law authorizing the creation of a professional organization similar to those authorized by ORS chapter 58, 60 or 70, as may be prescribed by the authority by rule.

(8) "Net patient revenue" means the total amount of revenue, after allowance for contractual amounts, charity care and bad debt, received for patient care and services, including:

(a) Value-based payments;

(b) Incentive payments; and

(c) Capitation payments or payments under any similar contractual arrangement for the prepayment or reimbursement of patient care and services.

(9) "Revenue" means:

(a) Net patient revenue; or

(b) The gross amount of premiums received by a health care entity that are derived from health benefit plans.

(10) "Transaction" means:

(a) A merger of a health care entity with another entity;

(b) An acquisition of one or more health care entities by another entity;

(c) New contracts, new clinical affiliations and new contracting affiliations that will eliminate or significantly reduce, as defined by the authority by rule, essential services;

(d) A corporate affiliation involving at least one health care entity; or

(e) Transactions to form a new partnership, joint venture, accountable care organization, parent organization or management services organization, as prescribed by the authority by rule.

SECTION 12. ORS 741.340 is amended to read:

741.340. The Oregon Health Authority, in developing and offering the health benefit package required by ORS 413.011 (1)(j), may not establish policies or procedures that discourage insurers from offering more comprehensive health benefit plans that provide greater consumer choice at a higher cost. The health benefit package approved by the Oregon Health Policy Board shall:

(1) Promote the provision of services through an integrated health home model that reduces unnecessary hospitalizations and emergency department visits.

(2) Require little or no cost sharing for evidence-based preventive care and services, such as care and services that have been shown to prevent acute exacerbations of disease symptoms in individuals with chronic illnesses.

(3) Create incentives for individuals to actively participate in their own health care and to maintain or improve their health status.

(4) Require a greater contribution by an enrollee to the cost of elective or discretionary health services.

(5) Include a defined set of health care services that are affordable, financially sustainable and [*based upon the prioritized list of health services developed and updated by the Health Evidence Review Commission under ORS 414.690*] **managed according to the clinical coverage policies developed under ORS 414.690**.

SECTION 13. ORS 414.694 is repealed.

SECTION 14. (1) As used in this section, "coordinated care organization" and "medical assistance" have the meanings given those terms in ORS 414.025.

(2) The Oregon Health Authority shall study:

(a) How the authority and coordinated care organizations can effectuate coverage decisions in the state medical assistance program based on the clinical coverage policies developed under ORS 414.690.

(b) Areas for potential alignment between the authority's fee-for-service payment system and the Oregon Integrated and Coordinated Health Care Delivery System established in ORS 414.570 that are compliant with federal law and within existing resources of the authority.

(3) The authority and the Health Evidence Review Commission shall study the implications and feasibility of developing, as part of the clinical coverage policies developed under ORS 414.690, diagnosis and treatment code pairings that indicate which health services are not medically necessary or appropriate for particular conditions.

(4) The authority and the commission shall submit a report in the manner provided by ORS 192.245 on the results of the studies conducted under subsections (2) and (3) of this section to the interim committees of the Legislative Assembly related to health care no later

than January 1, 2027.

SECTION 15. Section 14 of this 2026 Act is repealed on January 2, 2028.

SECTION 16. (1) As used in this section, "coordinated care organization," "health services" and "medical assistance" have the meanings given those terms in ORS 414.025.

(2) As part of the transition away from using the prioritized list of health services to determine the coverage of health services in the medical assistance program pursuant to the amendments to ORS 414.690 by section 4 of this 2026 Act, the Oregon Health Authority shall:

(a) Ensure that clinical coverage policies and other guidance developed by the Health Evidence Review Commission are published on a single webpage and readily accessible to interested parties, including but not limited to coordinated care organizations and providers.

(b) Develop tailored technical assistance and other materials for interested parties, including but not limited to medical assistance recipients, providers and coordinated care organizations.

(c) Direct the Health Evidence Review Commission to evaluate the availability of relevant utilization data and the resources necessary to leverage existing utilization data to inform the commission's clinical coverage policies developed under ORS 414.690.

(d) Consult with actuaries for the state medical assistance program to review data as expeditiously as possible after January 1, 2027, to ensure there is sufficient data for developing medical assistance rates for 2028.

(e) Report the authority's findings under paragraph (d) of this subsection to:

(A) The Medicaid Advisory Committee established under ORS 414.211;

(B) The committee convened by the authority related to quality and health outcomes;

(C) The workgroup convened by the authority to collaborate with coordinated care organizations on pharmacy policies; and

(D) The beneficiary advisory committee convened by the authority to receive input from medical assistance recipients.

SECTION 17. Section 16 of this 2026 Act is repealed on January 2, 2029.

SECTION 18. (1) The amendments to ORS 414.025, 414.065, 414.325, 414.689, 414.690, 414.698, 414.701, 414.735, 414.780, 415.500 and 741.340 by sections 1 to 12 of this 2026 Act become operative on January 1, 2027.

(2) The Oregon Health Authority and the Health Evidence Review Commission may take any action before the operative date specified in subsection (1) of this section that is necessary to enable the authority and the commission to exercise, on and after the operative date specified in subsection (1) of this section, all of the duties, functions and powers conferred on the authority and the commission by the amendments to ORS 414.025, 414.065, 414.325, 414.689, 414.690, 414.698, 414.701, 414.735, 414.780, 415.500 and 741.340 by sections 1 to 12 of this 2026 Act.

SECTION 19. This 2026 Act being necessary for the immediate preservation of the public peace, health and safety, an emergency is declared to exist, and this 2026 Act takes effect on its passage.