SENATE AMENDMENTS TO A-ENGROSSED HOUSE BILL 4070

By COMMITTEE ON EARLY CHILDHOOD AND BEHAVIORAL HEALTH

February 27

On page 1 of the printed A-engrossed bill, line 2, after "care;" delete the rest of the line and lines 3 through 5 and insert "creating new provisions; amending ORS 137.227, 137.228, 414.025, 414.595, 414.723, 414.780, 430.010, 430.021, 430.215, 430.256, 430.265, 430.306, 430.342, 430.345, 430.350, 430.359, 430.362, 430.364, 430.366, 430.380, 430.381, 430.401, 430.560, 430.610, 430.627, 430.630, 430.637, 430.640, 430.644, 430.646, 430.695, 430.705, 430.709, 430.905, 471.810, 675.523, 743A.012 and 743A.168; repealing ORS 430.315, 430.368, 430.565 and 430.634; and prescribing an effective date.".

On page 27, after line 5, insert:

"**SECTION 35.** 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)*] **(f)** An intern**, associate** or resident who is working under a board-approved supervisory contract in a clinical mental health field; or

"[*(h)*] **(g)** Any other clinician **who is credentialed by the state and** whose authorized scope of practice includes mental health diagnosis and 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 treat-

ment 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 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 36.** ORS 743A.012 is amended to read:

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

"(a) '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.

"(b) '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)*] **(F)** An intern**, associate** or resident who is working under a board-approved supervisory contract in a clinical mental health field; or

"[*(H)*] **(G)** Any other clinician **who is credentialed by the state and** whose authorized scope of practice includes mental health diagnosis and treatment.

"(c) '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.

"(d) 'Emergency medical condition' means a medical condition:

"(A) 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;

"(B) With respect to a pregnant woman who is having contractions, 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) That is a behavioral health crisis.

"(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.

"(f) 'Emergency medical service provider' has the meaning given that term in ORS 682.025.

"(g) 'Emergency medical services transport' means an emergency medical services provider's evaluation and stabilization of an individual experiencing a medical emergency and the transportation of the individual to the nearest medical facility capable of meeting the needs of the individual.

"(h) 'Emergency services' means, with respect to an emergency medical condition:

"(A) An emergency medical services transport;

"(B) An emergency medical screening exam or behavioral health assessment that is within the capability of the emergency department of a hospital, including ancillary services routinely available to the emergency department to evaluate such emergency medical condition; and

"(C) 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.

"(i) 'Grandfathered health plan' has the meaning given that term in ORS 743B.005.

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

"(k) 'Prior authorization' has the meaning given that term in ORS 743B.001.

"(L) '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 to or 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 when 9-1-1 is used.

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

"**SECTION 37.** ORS 414.723 is amended to read:

"414.723. (1) As used in this section:

"(a)(A) 'Audio only' means the use of audio telephone technology, permitting real-time communication between a health care provider and a patient for the purpose of diagnosis, consultation or treatment.

"(B) 'Audio only' does not include:

"(i) The use of facsimile, electronic mail or text messages.

"(ii) The delivery of health services that are customarily delivered by audio telephone technology and customarily not billed as separate services by a health care provider, such as the sharing of laboratory results.

"(b) 'Telemedicine' means the mode of delivering health services using information and telecommunication technologies to provide consultation and education or to facilitate diagnosis, treatment, care management or self-management of a patient's health care.

"(2) To encourage the efficient use of resources and to promote cost-effective procedures in accordance with ORS 413.011 (1)(L), the Oregon Health Authority shall reimburse the cost of health services delivered **by the providers described in subsection (3) of this section** using telemedicine, including but not limited to:

"(a) Health services transmitted via landlines, wireless communications, the Internet and telephone networks;

"(b) Synchronous or asynchronous transmissions using audio only, video only, audio and video and transmission of data from remote monitoring devices; and

"(c) Communications between providers or between one or more providers and one or more patients, family members, caregivers or guardians.

"**(3) The authority shall reimburse the cost of health services delivered using telemedicine by:**

"(a) A provider who is licensed or certified in this state;

"(b) A provider who is unlicensed, practices in this state and is employed by an entity with a certificate of approval issued by the authority;

"(c) A community mental health program;

"(d) A hospital; or

"(e) A federally qualified health center.

"[*(3)(a)*] **(4)(a)** The authority shall pay the same reimbursement for a health service regardless of whether the service is provided in person or using any permissible telemedicine application or technology.

"(b) Paragraph (a) of this subsection does not prohibit the use of value-based payment methods, including global budgets or capitated, bundled, risk-based or other value-based payment methods, and does not require that any value-based payment method reimburse telemedicine health services based on an equivalent fee-for-service rate.

"[*(4)*] **(5)** The authority shall include the costs of telemedicine services in its rate assumptions for payments made to clinics or other providers on a prepaid capitated basis.

"[*(5)*] **(6)** This section does not require the authority or a coordinated care organization to pay a provider for a service that is not included within the Healthcare Procedure Coding System or the American Medical Association's Current Procedural Terminology codes.

"[*(6)*] **(7)** The authority shall adopt rules to ensure that coordinated care organizations reimburse the cost of health services delivered using telemedicine, consistent with subsections (2) [*and*

(3)] **to (4)** of this section.

"**SECTION 38.** ORS 430.637 is amended to read:

"430.637. (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 **or substance use disorder** treatment [*or chemical dependency treatment and is not a coordinated care organization*] **and that is:**

"(A) Located in this state; or

"(B) Licensed and located in another state and accepts residents of this state for in-person treatment.

"(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.

"**SECTION 39.** ORS 743A.168 is amended to read:

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

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

"(b) 'Behavioral health condition' has the meaning prescribed by rule by the Department of Consumer and Business Services.

"(c) 'Behavioral health crisis' means a disruption in an insured'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 insured's mental or physical health.

"(d) 'Facility' means a [*corporate or governmental entity or other provider of services for the treatment of behavioral health conditions*] **facility located in this state that provides mental health or substance use disorder treatment**.

"(e) 'Generally accepted standards of care' means:

"(A) Standards of care and clinical practice guidelines that:

"(i) Are generally recognized by health care providers practicing in relevant clinical specialties; and

"(ii) Are based on valid, evidence-based sources; and

"(B) Products and services that:

"(i) Address the specific needs of a patient for the purpose of screening for, preventing, diagnosing, managing or treating an illness, injury or condition or symptoms of an illness, injury or condition;

"(ii) Are clinically appropriate in terms of type, frequency, extent, site and duration; and

"(iii) Are not primarily for the economic benefit of an insurer or payer or for the convenience of a patient, treating physician or other health care provider.

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

"(g) 'Median maximum allowable reimbursement rate' means the median of all maximum allowable reimbursement rates, minus incentive payments, paid for each billing code for each provider type during a calendar year.

"(h) 'Prior authorization' has the meaning given that term in ORS 743B.001.

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

"(j) 'Provider' means:

"(A) A behavioral health professional or medical professional licensed or certified in this state who has met the credentialing requirement of a group health insurer or an issuer of an individual health benefit plan that is not a grandfathered health plan as defined in ORS 743B.005 and is otherwise eligible to receive reimbursement for coverage under the policy;

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

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

"(D) A day or partial hospitalization program;

"(E) An outpatient service**,** as defined in ORS 430.010**, that provides treatment in this state**;

"(F) A licensed outpatient facility with a certified substance use disorder program that employs certified alcohol and drug counselor level providers; or

"(G) A provider organization certified by the Oregon Health Authority under subsection (9) of this section.

"(k) 'Relevant clinical specialties' includes but is not limited to:

"(A) Psychiatry;

"(B) Psychology;

"(C) Clinical sociology;

"(D) Addiction medicine and counseling; and

"(E) Behavioral health treatment.

"(L) 'Standards of care and clinical practice guidelines' includes but is not limited to:

"(A) Patient placement criteria;

"(B) Recommendations of agencies of the federal government; and

"(C) Drug labeling approved by the United States Food and Drug Administration.

"(m) 'Utilization review' has the meaning given that term in ORS 743B.001.

"(n) 'Valid, evidence-based sources' includes but is not limited to:

"(A) Peer-reviewed scientific studies and medical literature;

"(B) Recommendations of nonprofit health care provider professional associations; and

"(C) Specialty societies.

"(2) A group health insurance policy or an individual health benefit plan that is not a grandfathered health plan providing coverage for hospital or medical expenses, other than limited benefit coverage, shall provide coverage for expenses arising from the diagnosis of behavioral health conditions and medically necessary behavioral health treatment 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 behavioral health treatment:

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

"(b) The coverage of behavioral health treatment 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 of behavioral health treatment may be limited to treatment that is medically necessary as determined in accordance with this section and no more stringently under the policy than for other medical conditions.

"(c) The coverage of behavioral health treatment must include:

"(A) A behavioral health assessment;

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

"(i) To effectively treat the patient's underlying behavioral health condition rather than the mere amelioration of current symptoms such as suicidal ideation or psychosis; and

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

"(C) Treatment of co-occurring behavioral health conditions or medical conditions in a coordinated manner;

"(D) Treatment at the least intensive and least restrictive level of care that is safe and most effective and meets the needs of the insured's condition;

"(E) A lower level or less intensive care only if it is comparably as safe and effective as treatment at a higher level of service or intensity;

"(F) Treatment to maintain functioning or prevent deterioration;

"(G) Treatment for an appropriate duration based on the insured's particular needs;

"(H) Treatment appropriate to the unique needs of children and adolescents;

"(I) Treatment appropriate to the unique needs of older adults; and

"(J) Coordinated care and case management as defined by the Department of Consumer and Business Services by rule.

"(d) The coverage of behavioral health treatment may not limit coverage for treatment of pervasive or chronic behavioral health conditions to short-term or acute behavioral health treatment

at any level of care or placement.

"(e) A group health insurer or an issuer of an individual health benefit plan other than a grandfathered health plan shall have a network of providers of behavioral health treatment sufficient to meet the standards described in ORS 743B.505. If there is no in-network provider qualified to timely deliver, as defined by rule, medically necessary behavioral treatment to an insured in a geographic area, the group health insurer or issuer of an individual health benefit plan shall provide coverage of out-of-network medically necessary behavioral health treatment without any additional out-of-pocket costs if provided by an available out-of-network provider that enters into an agreement with the insurer to be reimbursed at in-network rates.

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

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

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

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

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

"(g) A group health insurer or an issuer of an individual health benefit plan other than a grandfathered health plan must use the same methodology to set reimbursement rates paid to behavioral health treatment providers that the group health insurer or issuer of an individual health benefit plan uses to set reimbursement rates for medical and surgical treatment providers.

"(h) A group health insurer or an issuer of an individual health benefit plan other than a grandfathered health plan must update the methodology and rates for reimbursing behavioral health treatment providers in a manner equivalent to the manner in which the group health insurer or issuer of an individual health benefit plan updates the methodology and rates for reimbursing medical and surgical treatment providers, unless otherwise required by federal law.

"(i) A group health insurer or an issuer of an individual health benefit plan other than a grandfathered health plan that reimburses out-of-network providers for medical or surgical services must reimburse out-of-network behavioral health treatment providers on the same terms and at a rate that is in parity with the rate paid to medical or surgical treatment providers.

"(j) Outpatient coverage of behavioral health treatment shall include follow-up in-home service or outpatient services if clinically indicated under criteria and guidelines described in subsection (5) of this section. The policy may limit coverage for in-home service to persons who are homebound under the care of a physician only if clinically indicated under criteria and guidelines described in subsection (5) of this section.

"(k)(A) Subject to ORS 743A.171 and 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 or issuer of an individual health benefit plan 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 staff of a group health insurer or issuer of an individual health benefit plan or personnel under contract to the group health insurer or issuer of an individual health benefit plan that is not a grandfathered health plan, or by a utilization review contractor, who shall have the authority to certify for or deny level of payment.

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

request.

"(C) Review shall be performed by or under the direction of a physician licensed under ORS 677.100 to 677.228, a psychologist licensed by the Oregon Board of Psychology, a clinical social worker licensed by the State Board of Licensed Social Workers or a professional counselor or marriage and family therapist licensed by the Oregon Board of Licensed Professional Counselors and Therapists, in accordance with standards of the National Committee for Quality Assurance or Medicare review standards of the Centers for Medicare and Medicaid Services.

"(D) Review may involve prior authorization, concurrent review of the continuation of treatment, post-treatment review or any combination of these. However, if prior authorization is required, provision shall be made to allow for payment of urgent or emergency admissions, subject to subsequent review. If prior authorization is not required, group health insurers and issuers of individual health benefit plans that are not grandfathered health plans 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 and issuers of individual health benefit plans that are not grandfathered health plans 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.

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

"(3) Except as provided in ORS 743A.171, this section does not prohibit a group health insurer or issuer of an individual health benefit plan that is not a grandfathered health plan from managing the provision of benefits through common methods, including but not limited to selectively contracted panels, health plan benefit differential designs, preadmission screening, prior authorization of services, utilization review or other mechanisms designed to limit eligible expenses to those described in subsection (2)(b) of this section provided such methods comply with the requirements of this section.

"(4) The Legislative Assembly finds that health care cost containment is necessary and intends to encourage health insurance plans designed to achieve cost containment by ensuring that reimbursement is limited to appropriate utilization under criteria incorporated into the insurance, either directly or by reference, in accordance with this section.

"(5)(a) Any medical necessity, utilization or other clinical review conducted for the diagnosis, prevention or treatment of behavioral health conditions or relating to service intensity, level of care placement, continued stay or discharge must be based solely on the following:

"(A) The current generally accepted standards of care.

"(B) For level of care placement decisions, the most recent version of the levels of care placement criteria developed by the nonprofit professional association for the relevant clinical specialty.

"(C) For medical necessity, utilization or other clinical review conducted for the diagnosis, prevention or treatment of behavioral health conditions that does not involve level of care placement decisions, other criteria and guidelines may be utilized if such criteria and guidelines are based on the current generally accepted standards of care including valid, evidence-based sources and current treatment criteria or practice guidelines developed by the nonprofit professional association

for the relevant clinical specialty. Such other criteria and guidelines must be made publicly available and made available to insureds upon request to the extent permitted by copyright laws.

"(b) This subsection does not prevent a group health insurer or an issuer of an individual health benefit plan other than a grandfathered health plan from using criteria that:

"(A) Are outside the scope of criteria and guidelines described in paragraph (a)(B) of this subsection, if the guidelines were developed in accordance with the current generally accepted standards of care; or

"(B) Are based on advancements in technology of types of care that are not addressed in the most recent versions of sources specified in paragraph (a)(B) of this subsection, if the guidelines were developed in accordance with current generally accepted standards of care.

"(c) For all level of care placement decisions, an insurer shall authorize placement at the level of care consistent with the insured's score or assessment using the relevant level of care placement criteria and guidelines as specified in paragraph (a)(B) of this subsection. If the level of care indicated by the criteria and guidelines is not available, the insurer shall authorize the next higher level of care. If there is disagreement about the appropriate level of care, the insurer shall provide to the provider of the service the full details of the insurer's scoring or assessment using the relevant level of care placement criteria and guidelines specified in paragraph (a)(B) of this subsection.

"(6) To ensure the proper use of any criteria and guidelines described in subsection (5) of this section, a group health insurer or an issuer of an individual health benefit plan shall provide, at no cost:

"(a) A formal education program, presented by nonprofit clinical specialty associations or other entities authorized by the department, to educate the insurer's or the issuer's staff and any individuals described in subsection (2)(k) of this section who conduct reviews.

"(b) To stakeholders, including participating providers and insureds, the criteria and guidelines described in subsection (5) of this section and any education or training materials or resources regarding the criteria and guidelines.

"(7) This section does not prevent a group health insurer or issuer of an individual health benefit plan that is not a grandfathered health plan 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 or issuer of an individual health benefit plan that is not a grandfathered health plan is not required to contract with all providers that are eligible for reimbursement under this section.

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

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

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

"(B) A long-term residential mental health program that lasts longer than 45 days unless clinically indicated under criteria and guidelines described in subsection (5) of this section;

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

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

"(E) Support groups.

"(b) Notwithstanding paragraph (a)(A) of this subsection, an insured may receive covered outpatient services under the terms of the insured's policy while the insured is living temporarily in a sheltered living situation.

"(9) The Oregon Health Authority shall establish a process for the certification of an organization described in subsection (1)(j)(G) 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.

"(10) The Oregon Health Authority shall adopt by rule standards for the certification provided under subsection (9) of this section to ensure that a certified provider organization offers a distinct and specialized program for the treatment of mental or nervous conditions.

"(11) 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 (9) 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 (9) of this section.

"(12) 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 in accordance with this section. This section does not prohibit an insurer from requiring a provider organization certified by the Oregon Health Authority under subsection (9) of this section to meet the insurer's credentialing requirements as a condition of entering into a contract.

"(13) 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. The director shall adopt rules making it a violation of this section for a group health insurer or issuer of an individual health benefit plan other than a grandfathered health plan to require providers to bill using a specific billing code or to restrict the reimbursement paid for particular billing codes other than on the basis of medical necessity.

"(14) This section does not:

"(a) Prohibit an insured from receiving behavioral health treatment from an out-of-network provider or prevent an out-of-network behavioral health provider from billing the insured for any unreimbursed cost of treatment.

"(b) Prohibit the use of value-based payment methods, including global budgets or capitated, bundled, risk-based or other value-based payment methods.

"(c) Require that any value-based payment method reimburse behavioral health services based on an equivalent fee-for-service rate.

"**SECTION 40. The amendments to ORS 414.025, 414.723, 430.637, 743A.012 and 743A.168 by sections 35 to 39 of this 2026 Act become operative on January 1, 2027.**

"**SECTION 41. This 2026 Act takes effect on the 91st day after the date on which the 2026 regular session of the Eighty-third Legislative Assembly adjourns sine die.**".
