

Requested by Senator REYNOLDS

**PROPOSED AMENDMENTS TO  
A-ENGROSSED HOUSE BILL 4070**

1 On page 1 of the printed A-engrossed bill, line 2, after “care;” delete the  
2 rest of the line and lines 3 through 5 and insert “creating new provisions;  
3 amending ORS 137.227, 137.228, 414.025, 414.595, 414.723, 414.780, 430.010,  
4 430.021, 430.215, 430.256, 430.265, 430.306, 430.342, 430.345, 430.350, 430.359,  
5 430.362, 430.364, 430.366, 430.380, 430.381, 430.401, 430.560, 430.610, 430.627,  
6 430.630, 430.637, 430.640, 430.644, 430.646, 430.695, 430.705, 430.709, 430.905,  
7 471.810, 675.523, 743A.012 and 743A.168; repealing ORS 430.315, 430.368,  
8 430.565 and 430.634; and prescribing an effective date.”.

9 On page 27, after line 5, insert:

10 **“SECTION 35.** ORS 414.025 is amended to read:

11 “414.025. As used in this chapter and ORS chapters 411 and 413, unless  
12 the context or a specially applicable statutory definition requires otherwise:

13 “(1)(a) ‘Alternative payment methodology’ means a payment other than a  
14 fee-for-services payment, used by coordinated care organizations as compen-  
15 sation for the provision of integrated and coordinated health care and ser-  
16 vices.

17 “(b) ‘Alternative payment methodology’ includes, but is not limited to:

18 “(A) Shared savings arrangements;

19 “(B) Bundled payments; and

20 “(C) Payments based on episodes.

21 “(2) ‘Behavioral health assessment’ means an evaluation by a behavioral

1 health clinician, in person or using telemedicine, to determine a patient's  
2 need for immediate crisis stabilization.

3 “(3) ‘Behavioral health clinician’ means:

4 “(a) A licensed psychiatrist;

5 “(b) A licensed psychologist;

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

8 “(d) A licensed clinical social worker;

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

11 “[*f*] A *certified clinical social work associate*;

12 “[*g*] (f) An intern, **associate** or resident who is working under a  
13 board-approved supervisory contract in a clinical mental health field; or

14 “[*h*] (g) Any other clinician **who is credentialed by the state and**  
15 whose authorized scope of practice includes mental health diagnosis and  
16 treatment.

17 “(4) ‘Behavioral health crisis’ means a disruption in an individual’s men-  
18 tal or emotional stability or functioning resulting in an urgent need for im-  
19 mediate outpatient treatment in an emergency department or admission to  
20 a hospital to prevent a serious deterioration in the individual’s mental or  
21 physical health.

22 “(5) ‘Behavioral health home’ means a mental health disorder or sub-  
23 stance use disorder treatment organization, as defined by the Oregon Health  
24 Authority by rule, that provides integrated health care to individuals whose  
25 primary diagnoses are mental health disorders or substance use disorders.

26 “(6) ‘Category of aid’ means assistance provided by the Oregon Supple-  
27 mental Income Program, aid granted under ORS 411.877 to 411.896 and  
28 412.001 to 412.069 or federal Supplemental Security Income payments.

29 “(7) ‘Community health worker’ means an individual who meets quali-  
30 fication criteria adopted by the authority under ORS 414.665 and who:

- 1       “(a) Has expertise or experience in public health;
- 2       “(b) Works in an urban or rural community, either for pay or as a vol-  
3       unteer in association with a local health care system;
- 4       “(c) To the extent practicable, shares ethnicity, language, socioeconomic  
5       status and life experiences with the residents of the community the worker  
6       serves;
- 7       “(d) Assists members of the community to improve their health and in-  
8       creases the capacity of the community to meet the health care needs of its  
9       residents and achieve wellness;
- 10       “(e) Provides health education and information that is culturally appro-  
11       priate to the individuals being served;
- 12       “(f) Assists community residents in receiving the care they need;
- 13       “(g) May give peer counseling and guidance on health behaviors; and
- 14       “(h) May provide direct services such as first aid or blood pressure  
15       screening.
- 16       “(8) ‘Coordinated care organization’ means an organization meeting cri-  
17       teria adopted by the Oregon Health Authority under ORS 414.572.
- 18       “(9) ‘Dental subcontractor’ means a prepaid managed care health services  
19       organization that enters into a noncomprehensive risk contract with a coor-  
20       dinated care organization or the Oregon Health Authority to provide dental  
21       services to medical assistance recipients.
- 22       “(10) ‘Doula’ means a trained professional who provides continuous phys-  
23       ical, emotional and informational support to an individual during pregnancy,  
24       labor and delivery or the postpartum period to help the individual achieve  
25       the healthiest and most satisfying experience possible.
- 26       “(11) ‘Dually eligible for Medicare and Medicaid’ means, with respect to  
27       eligibility for enrollment in a coordinated care organization, that an indi-  
28       vidual is eligible for health services funded by Title XIX of the Social Se-  
29       curity Act and is:
- 30       “(a) Eligible for or enrolled in Part A of Title XVIII of the Social Security

1 Act; or

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

3 “(12)(a) ‘Family support specialist’ means an individual who meets quali-  
4 fication criteria adopted by the authority under ORS 414.665 and who pro-  
5 vides supportive services to and has experience parenting a child who:

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

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

10 “(b) A ‘family support specialist’ may be a peer wellness specialist or a  
11 peer support specialist.

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

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

18 “(15) ‘Health services’ means at least so much of each of the following  
19 as are funded by the Legislative Assembly based upon the prioritized list of  
20 health services compiled by the Health Evidence Review Commission under  
21 ORS 414.690:

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

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

28 “(c) Prescription drugs;

29 “(d) Laboratory and X-ray services;

30 “(e) Medical equipment and supplies;

1 “(f) Mental health services;  
2 “(g) Chemical dependency services;  
3 “(h) Emergency dental services;  
4 “(i) Nonemergency dental services;  
5 “(j) Provider services, other than services described in paragraphs (a) to  
6 (i), (k), (L) and (m) of this subsection, defined by federal law that may be  
7 included in the state’s medical assistance program;  
8 “(k) Emergency hospital services;  
9 “(L) Outpatient hospital services; and  
10 “(m) Inpatient hospital services.  
11 “(16) ‘Income’ has the meaning given that term in ORS 411.704.  
12 “(17)(a) ‘Integrated health care’ means care provided to individuals and  
13 their families in a patient centered primary care home or behavioral health  
14 home by licensed primary care clinicians, behavioral health clinicians and  
15 other care team members, working together to address one or more of the  
16 following:  
17 “(A) Mental illness.  
18 “(B) Substance use disorders.  
19 “(C) Health behaviors that contribute to chronic illness.  
20 “(D) Life stressors and crises.  
21 “(E) Developmental risks and conditions.  
22 “(F) Stress-related physical symptoms.  
23 “(G) Preventive care.  
24 “(H) Ineffective patterns of health care utilization.  
25 “(b) As used in this subsection, ‘other care team members’ includes but  
26 is not limited to:  
27 “(A) Qualified mental health professionals or qualified mental health as-  
28 sociates meeting requirements adopted by the Oregon Health Authority by  
29 rule;  
30 “(B) Peer wellness specialists;

1 “(C) Peer support specialists;

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

4 “(E) Personal health navigators; or

5 “(F) Other qualified individuals approved by the Oregon Health Author-  
6 ity.

7 “(18) ‘Investments and savings’ means cash, securities as defined in ORS  
8 59.015, negotiable instruments as defined in ORS 73.0104 and such similar  
9 investments or savings as the department or the authority may establish by  
10 rule that are available to the applicant or recipient to contribute toward  
11 meeting the needs of the applicant or recipient.

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

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

25 “(21) ‘Mental health drug’ means a type of legend drug, as defined in ORS  
26 414.325, specified by the Oregon Health Authority by rule, including but not  
27 limited to:

28 “(a) Therapeutic class 7 ataractics-tranquilizers; and

29 “(b) Therapeutic class 11 psychostimulants-antidepressants.

30 “(22) ‘Patient centered primary care home’ means a health care team or

1 clinic that is organized in accordance with the standards established by the  
2 Oregon Health Authority under ORS 414.655 and that incorporates the fol-  
3 lowing core attributes:

4 “(a) Access to care;

5 “(b) Accountability to consumers and to the community;

6 “(c) Comprehensive whole person care;

7 “(d) Continuity of care;

8 “(e) Coordination and integration of care; and

9 “(f) Person and family centered care.

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

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

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

18 “(24) ‘Peer wellness specialist’ means an individual who meets qualifica-  
19 tion criteria adopted by the authority under ORS 414.665 and who is re-  
20 sponsible for assessing mental health and substance use disorder service and  
21 support needs of a member of a coordinated care organization through com-  
22 munity outreach, assisting members with access to available services and  
23 resources, addressing barriers to services and providing education and in-  
24 formation about available resources for individuals with mental health or  
25 substance use disorders in order to reduce stigma and discrimination toward  
26 consumers of mental health and substance use disorder services and to assist  
27 the member in creating and maintaining recovery, health and wellness.

28 “(25) ‘Person centered care’ means care that:

29 “(a) Reflects the individual patient’s strengths and preferences;

30 “(b) Reflects the clinical needs of the patient as identified through an

1 individualized assessment; and

2 “(c) Is based upon the patient’s goals and will assist the patient in  
3 achieving the goals.

4 “(26) ‘Personal health navigator’ means an individual who meets quali-  
5 fication criteria adopted by the authority under ORS 414.665 and who pro-  
6 vides information, assistance, tools and support to enable a patient to make  
7 the best health care decisions in the patient’s particular circumstances and  
8 in light of the patient’s needs, lifestyle, combination of conditions and de-  
9 sired outcomes.

10 “(27) ‘Prepaid managed care health services organization’ means a man-  
11 aged dental care, mental health or chemical dependency organization that  
12 contracts with the authority under ORS 414.654 or with a coordinated care  
13 organization on a prepaid capitated basis to provide health services to med-  
14 ical assistance recipients.

15 “(28) ‘Quality measure’ means the health outcome and quality measures  
16 and benchmarks identified by the Health Plan Quality Metrics Committee  
17 and the metrics and scoring subcommittee in accordance with ORS 413.017  
18 (4) and 413.022 and the quality metrics developed by the Behavioral Health  
19 Committee in accordance with ORS 413.017 (5).

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

24 “(b) ‘Quality of life in general measure’ does not mean an assessment of  
25 the value, effectiveness or cost-effectiveness of a treatment during a clinical  
26 trial in which a study participant is asked to rate the participant’s physical  
27 function, pain, general health, vitality, social functions or other similar do-  
28 mains.

29 “(30) ‘Resources’ has the meaning given that term in ORS 411.704. For  
30 eligibility purposes, ‘resources’ does not include charitable contributions

1 raised by a community to assist with medical expenses.

2 “(31) ‘Social determinants of health’ means:

3 “(a) Nonmedical factors that influence health outcomes;

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

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

9 “(32) ‘Tribal traditional health worker’ means an individual who meets  
10 qualification criteria adopted by the authority under ORS 414.665 and who:

11 “(a) Has expertise or experience in public health;

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

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

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

20 “(e) Provides health education and information that is culturally appro-  
21 priate to the individuals being served;

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

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

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

25 “(33)(a) ‘Youth support specialist’ means an individual who meets quali-  
26 fication criteria adopted by the authority under ORS 414.665 and who, based  
27 on a similar life experience, provides supportive services to an individual  
28 who:

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

30 “(B)(i) Is a current or former consumer of mental health or addiction

1 treatment; or

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

4 “(b) A ‘youth support specialist’ may be a peer wellness specialist or a  
5 peer support specialist.

6 **“SECTION 36.** ORS 743A.012 is amended to read:

7 “743A.012. (1) As used in this section:

8 “(a) ‘Behavioral health assessment’ means an evaluation by a behavioral  
9 health clinician, in person or using telemedicine, to determine a patient’s  
10 need for immediate crisis stabilization.

11 “(b) ‘Behavioral health clinician’ means:

12 “(A) A licensed psychiatrist;

13 “(B) A licensed psychologist;

14 “(C) A licensed nurse practitioner with a specialty in psychiatric mental  
15 health;

16 “(D) A licensed clinical social worker;

17 “(E) A licensed professional counselor or licensed marriage and family  
18 therapist;

19 “[*F*] A certified clinical social work associate;]

20 “[*G*] (F) An intern, **associate** or resident who is working under a  
21 board-approved supervisory contract in a clinical mental health field; or

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

25 “(c) ‘Behavioral health crisis’ means a disruption in an individual’s men-  
26 tal or emotional stability or functioning resulting in an urgent need for im-  
27 mediate outpatient treatment in an emergency department or admission to  
28 a hospital to prevent a serious deterioration in the individual’s mental or  
29 physical health.

30 “(d) ‘Emergency medical condition’ means a medical condition:

1       “(A) That manifests itself by acute symptoms of sufficient severity, in-  
2 cluding severe pain, that a prudent layperson possessing an average knowl-  
3 edge of health and medicine would reasonably expect that failure to receive  
4 immediate medical attention would:

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

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

8       “(iii) Result in serious dysfunction of any bodily organ or part;

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

13       “(C) That is a behavioral health crisis.

14       “(e) ‘Emergency medical screening exam’ means the medical history, ex-  
15 amination, ancillary tests and medical determinations required to ascertain  
16 the nature and extent of an emergency medical condition.

17       “(f) ‘Emergency medical service provider’ has the meaning given that term  
18 in ORS 682.025.

19       “(g) ‘Emergency medical services transport’ means an emergency medical  
20 services provider’s evaluation and stabilization of an individual experiencing  
21 a medical emergency and the transportation of the individual to the nearest  
22 medical facility capable of meeting the needs of the individual.

23       “(h) ‘Emergency services’ means, with respect to an emergency medical  
24 condition:

25       “(A) An emergency medical services transport;

26       “(B) An emergency medical screening exam or behavioral health assess-  
27 ment that is within the capability of the emergency department of a hospital,  
28 including ancillary services routinely available to the emergency department  
29 to evaluate such emergency medical condition; and

30       “(C) Such further medical examination and treatment as are required

1 under 42 U.S.C. 1395dd to stabilize a patient, to the extent the examination  
2 and treatment are within the capability of the staff and facilities available  
3 at a hospital.

4 “(i) ‘Grandfathered health plan’ has the meaning given that term in ORS  
5 743B.005.

6 “(j) ‘Health benefit plan’ has the meaning given that term in ORS  
7 743B.005.

8 “(k) ‘Prior authorization’ has the meaning given that term in ORS  
9 743B.001.

10 “(L) ‘Stabilize’ means to provide medical treatment as necessary to:

11 “(A) Ensure that, within reasonable medical probability, no material de-  
12 terioration of an emergency medical condition is likely to occur during or  
13 to result from the transfer of the patient to or from a facility; and

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

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

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

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

22 “(A) The coordination of benefits;

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

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

27 “(D) Applicable cost-sharing; and

28 “(b) For the services of a nonparticipating provider:

29 “(A) Without imposing any administrative requirement or limitation on  
30 coverage that is more restrictive than requirements or limitations that apply

1 to participating providers;

2 “(B) Without imposing a copayment amount or coinsurance rate that ex-  
3 ceeds the amount or rate for participating providers;

4 “(C) Without imposing a deductible, unless the deductible applies gener-  
5 ally to nonparticipating providers; and

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

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

10 “(a) What constitutes an emergency medical condition;

11 “(b) The coverage provided for emergency services;

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

13 “(d) The appropriate use of 9-1-1.

14 “(5) An insurer offering a health benefit plan may not discourage appro-  
15 priate use of 9-1-1 and may not deny coverage for emergency services when  
16 9-1-1 is used.

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

18 **“SECTION 37.** ORS 414.723 is amended to read:

19 “414.723. (1) As used in this section:

20 “(a)(A) ‘Audio only’ means the use of audio telephone technology, per-  
21 mitting real-time communication between a health care provider and a pa-  
22 tient for the purpose of diagnosis, consultation or treatment.

23 “(B) ‘Audio only’ does not include:

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

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

28 “(b) ‘Telemedicine’ means the mode of delivering health services using  
29 information and telecommunication technologies to provide consultation and  
30 education or to facilitate diagnosis, treatment, care management or self-

1 management of a patient's health care.

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

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

9 “(b) Synchronous or asynchronous transmissions using audio only, video  
10 only, audio and video and transmission of data from remote monitoring de-  
11 vices; and

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

14 “**(3) The authority shall reimburse the cost of health services de-**  
15 **livered using telemedicine by:**

16 “**(a) A provider who is licensed or certified in this state;**

17 “**(b) A provider who is unlicensed, practices in this state and is**  
18 **employed by an entity with a certificate of approval issued by the au-**  
19 **thority;**

20 “**(c) A community mental health program;**

21 “**(d) A hospital; or**

22 “**(e) A federally qualified health center.**

23 “[~~(3)(a)~~] **(4)(a)** The authority shall pay the same reimbursement for a  
24 health service regardless of whether the service is provided in person or us-  
25 ing any permissible telemedicine application or technology.

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

1        “[4] (5) The authority shall include the costs of telemedicine services in  
2 its rate assumptions for payments made to clinics or other providers on a  
3 prepaid capitated basis.

4        “[5] (6) This section does not require the authority or a coordinated care  
5 organization to pay a provider for a service that is not included within the  
6 Healthcare Procedure Coding System or the American Medical Association’s  
7 Current Procedural Terminology codes.

8        “[6] (7) The authority shall adopt rules to ensure that coordinated care  
9 organizations reimburse the cost of health services delivered using telemed-  
10 icine, consistent with subsections (2) [and (3)] **to (4)** of this section.

11        **“SECTION 38.** ORS 430.637 is amended to read:

12        “430.637. (1) As used in this section:

13        “(a) ‘Assessment’ means an on-site quality assessment of an organizational  
14 provider that is conducted:

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

17        “(B) By the Oregon Health Authority, another state agency or a con-  
18 tractor on behalf of the authority or another state agency; and

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

20        “(b) ‘Organizational provider’ means an organization that provides mental  
21 health **or substance use disorder** treatment [*or chemical dependency treat-*  
22 *ment and is not a coordinated care organization*] **and that is:**

23        **“(A) Located in this state; or**

24        **“(B) Licensed and located in another state and accepts residents of**  
25 **this state for in-person treatment.**

26        “(2) The Oregon Health Authority shall convene a committee, in accord-  
27 ance with ORS 183.333, to advise the authority with respect to the adoption,  
28 by rule, of criteria for an assessment. The advisory committee shall advise  
29 the authority during the development of the criteria. The advisory committee  
30 shall be reconvened as needed to advise the authority with respect to up-

1 dating the criteria to conform to changes in national accreditation standards  
2 or federal requirements for health plans and to advise the authority on op-  
3 portunities to improve the assessment process. The advisory committee shall  
4 include, but is not limited to:

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

7 “(b) Representatives of organizational providers;

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

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

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

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

16 “(b) Procedures for conducting an assessment;

17 “(c) Procedures to eliminate redundant reporting requirements for organ-  
18 izational providers; and

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

21 “(4) If another state agency, or a contractor on behalf of the state agency,  
22 conducts an assessment that meets the criteria adopted by the authority un-  
23 der subsection (2) of this section, the authority may rely on the assessment  
24 as evidence that the organizational provider meets the assessment require-  
25 ment for receiving a certificate of approval.

26 “(5) The authority shall provide a report of an assessment to the organ-  
27 izational provider that was assessed and, upon request, to a coordinated care  
28 organization, insurer or health care service contractor.

29 “(6) If an organizational provider has not been accredited by a national  
30 organization that is acceptable to a coordinated care organization, the coor-

1 dinated care organization shall rely on the assessment conducted in accord-  
2 ance with the criteria adopted under subsection (2) of this section as  
3 evidence that the organizational provider meets the assessment requirement.

4 “(7) This section does not:

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

9 “(b) Require a coordinated care organization to contract with an organ-  
10 izational provider.

11 “(8)(a) The authority shall adopt by rule standards for determining  
12 whether information requested by a coordinated care organization from an  
13 organizational provider is redundant with respect to the reporting require-  
14 ments for an assessment or if the information is outside of the scope of the  
15 assessment criteria.

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

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

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

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

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

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

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

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

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

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

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

12 “(c) The authority shall provide training to coordinated care organization  
13 staff who are responsible for processing credentialing requests on the use of  
14 the database.

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

16 “743A.168. (1) As used in this section:

17 “(a) ‘Behavioral health assessment’ means an evaluation by a provider, in  
18 person or using telemedicine, to determine a patient’s need for behavioral  
19 health treatment.

20 “(b) ‘Behavioral health condition’ has the meaning prescribed by rule by  
21 the Department of Consumer and Business Services.

22 “(c) ‘Behavioral health crisis’ means a disruption in an insured’s mental  
23 or emotional stability or functioning resulting in an urgent need for imme-  
24 diate outpatient treatment in an emergency department or admission to a  
25 hospital to prevent a serious deterioration in the insured’s mental or phys-  
26 ical health.

27 “(d) ‘Facility’ means a [*corporate or governmental entity or other provider*  
28 *of services for the treatment of behavioral health conditions*] **facility located**  
29 **in this state that provides mental health or substance use disorder**  
30 **treatment.**

1 “(e) ‘Generally accepted standards of care’ means:  
2 “(A) Standards of care and clinical practice guidelines that:  
3 “(i) Are generally recognized by health care providers practicing in rele-  
4 vant clinical specialties; and  
5 “(ii) Are based on valid, evidence-based sources; and  
6 “(B) Products and services that:  
7 “(i) Address the specific needs of a patient for the purpose of screening  
8 for, preventing, diagnosing, managing or treating an illness, injury or con-  
9 dition or symptoms of an illness, injury or condition;  
10 “(ii) Are clinically appropriate in terms of type, frequency, extent, site  
11 and duration; and  
12 “(iii) Are not primarily for the economic benefit of an insurer or payer  
13 or for the convenience of a patient, treating physician or other health care  
14 provider.  
15 “(f) ‘Group health insurer’ means an insurer, a health maintenance or-  
16 ganization or a health care service contractor.  
17 “(g) ‘Median maximum allowable reimbursement rate’ means the median  
18 of all maximum allowable reimbursement rates, minus incentive payments,  
19 paid for each billing code for each provider type during a calendar year.  
20 “(h) ‘Prior authorization’ has the meaning given that term in ORS  
21 743B.001.  
22 “(i) ‘Program’ means a particular type or level of service that is organ-  
23 izationally distinct within a facility.  
24 “(j) ‘Provider’ means:  
25 “(A) A behavioral health professional or medical professional licensed or  
26 certified in this state who has met the credentialing requirement of a group  
27 health insurer or an issuer of an individual health benefit plan that is not  
28 a grandfathered health plan as defined in ORS 743B.005 and is otherwise el-  
29 igible to receive reimbursement for coverage under the policy;  
30 “(B) A health care facility as defined in ORS 433.060;

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

2 “(D) A day or partial hospitalization program;

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

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

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

10 “(k) ‘Relevant clinical specialties’ includes but is not limited to:

11 “(A) Psychiatry;

12 “(B) Psychology;

13 “(C) Clinical sociology;

14 “(D) Addiction medicine and counseling; and

15 “(E) Behavioral health treatment.

16 “(L) ‘Standards of care and clinical practice guidelines’ includes but is  
17 not limited to:

18 “(A) Patient placement criteria;

19 “(B) Recommendations of agencies of the federal government; and

20 “(C) Drug labeling approved by the United States Food and Drug Ad-  
21 ministration.

22 “(m) ‘Utilization review’ has the meaning given that term in ORS  
23 743B.001.

24 “(n) ‘Valid, evidence-based sources’ includes but is not limited to:

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

26 “(B) Recommendations of nonprofit health care provider professional as-  
27 sociations; and

28 “(C) Specialty societies.

29 “(2) A group health insurance policy or an individual health benefit plan  
30 that is not a grandfathered health plan providing coverage for hospital or

1 medical expenses, other than limited benefit coverage, shall provide coverage  
2 for expenses arising from the diagnosis of behavioral health conditions and  
3 medically necessary behavioral health treatment at the same level as, and  
4 subject to limitations no more restrictive than, those imposed on coverage  
5 or reimbursement of expenses arising from treatment for other medical con-  
6 ditions. The following apply to coverage for behavioral health treatment:

7 “(a) The coverage may be made subject to provisions of the policy that  
8 apply to other benefits under the policy, including but not limited to pro-  
9 visions relating to copayments, deductibles and coinsurance. Copayments,  
10 deductibles and coinsurance for treatment in health care facilities or resi-  
11 dential facilities may not be greater than those under the policy for expenses  
12 of hospitalization in the treatment of other medical conditions. Copayments,  
13 deductibles and coinsurance for outpatient treatment may not be greater  
14 than those under the policy for expenses of outpatient treatment of other  
15 medical conditions.

16 “(b) The coverage of behavioral health treatment may not be made subject  
17 to treatment limitations, limits on total payments for treatment, limits on  
18 duration of treatment or financial requirements unless similar limitations  
19 or requirements are imposed on coverage of other medical conditions. The  
20 coverage of eligible expenses of behavioral health treatment may be limited  
21 to treatment that is medically necessary as determined in accordance with  
22 this section and no more stringently under the policy than for other medical  
23 conditions.

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

25 “(A) A behavioral health assessment;

26 “(B) No less than the level of services determined to be medically neces-  
27 sary in a behavioral health assessment of the specific needs of a patient or  
28 in a patient’s care plan:

29 “(i) To effectively treat the patient’s underlying behavioral health condi-  
30 tion rather than the mere amelioration of current symptoms such as suicidal

1 ideation or psychosis; and

2 “(ii) For care following a behavioral health crisis, to transition the pa-  
3 tient to a lower level of care;

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

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

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

10 “(F) Treatment to maintain functioning or prevent deterioration;

11 “(G) Treatment for an appropriate duration based on the insured’s par-  
12 ticular needs;

13 “(H) Treatment appropriate to the unique needs of children and adoles-  
14 cents;

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

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

18 “(d) The coverage of behavioral health treatment may not limit coverage  
19 for treatment of pervasive or chronic behavioral health conditions to short-  
20 term or acute behavioral health treatment at any level of care or placement.

21 “(e) A group health insurer or an issuer of an individual health benefit  
22 plan other than a grandfathered health plan shall have a network of pro-  
23 viders of behavioral health treatment sufficient to meet the standards de-  
24 scribed in ORS 743B.505. If there is no in-network provider qualified to  
25 timely deliver, as defined by rule, medically necessary behavioral treatment  
26 to an insured in a geographic area, the group health insurer or issuer of an  
27 individual health benefit plan shall provide coverage of out-of-network med-  
28 ically necessary behavioral health treatment without any additional out-of-  
29 pocket costs if provided by an available out-of-network provider that enters  
30 into an agreement with the insurer to be reimbursed at in-network rates.

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

2 “(A) The provider is approved or certified by the Oregon Health Author-  
3 ity;

4 “(B) The provider is accredited for the particular level of care for which  
5 reimbursement is being requested by the Joint Commission or the Commis-  
6 sion on Accreditation of Rehabilitation Facilities;

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

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

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

15 “(h) A group health insurer or an issuer of an individual health benefit  
16 plan other than a grandfathered health plan must update the methodology  
17 and rates for reimbursing behavioral health treatment providers in a manner  
18 equivalent to the manner in which the group health insurer or issuer of an  
19 individual health benefit plan updates the methodology and rates for reim-  
20 bursing medical and surgical treatment providers, unless otherwise required  
21 by federal law.

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

27 “(j) Outpatient coverage of behavioral health treatment shall include  
28 follow-up in-home service or outpatient services if clinically indicated under  
29 criteria and guidelines described in subsection (5) of this section. The policy  
30 may limit coverage for in-home service to persons who are homebound under

1 the care of a physician only if clinically indicated under criteria and guide-  
2 lines described in subsection (5) of this section.

3 “(k)(A) Subject to ORS 743A.171 and to the patient or client  
4 confidentiality provisions of ORS 40.235 relating to physicians, ORS 40.240  
5 relating to nurse practitioners, ORS 40.230 relating to psychologists, ORS  
6 40.250 and 675.580 relating to licensed clinical social workers and ORS 40.262  
7 relating to licensed professional counselors and licensed marriage and family  
8 therapists, a group health insurer or issuer of an individual health benefit  
9 plan may provide for review for level of treatment of admissions and con-  
10 tinued stays for treatment in health facilities, residential facilities, day or  
11 partial hospitalization programs and outpatient services by either staff of a  
12 group health insurer or issuer of an individual health benefit plan or per-  
13 sonnel under contract to the group health insurer or issuer of an individual  
14 health benefit plan that is not a grandfathered health plan, or by a utiliza-  
15 tion review contractor, who shall have the authority to certify for or deny  
16 level of payment.

17 “(B) Review shall be made according to criteria made available to pro-  
18 vidors in advance upon request.

19 “(C) Review shall be performed by or under the direction of a physician  
20 licensed under ORS 677.100 to 677.228, a psychologist licensed by the Oregon  
21 Board of Psychology, a clinical social worker licensed by the State Board  
22 of Licensed Social Workers or a professional counselor or marriage and  
23 family therapist licensed by the Oregon Board of Licensed Professional  
24 Counselors and Therapists, in accordance with standards of the National  
25 Committee for Quality Assurance or Medicare review standards of the Cen-  
26 ters for Medicare and Medicaid Services.

27 “(D) Review may involve prior authorization, concurrent review of the  
28 continuation of treatment, post-treatment review or any combination of  
29 these. However, if prior authorization is required, provision shall be made  
30 to allow for payment of urgent or emergency admissions, subject to subse-

1 quent review. If prior authorization is not required, group health insurers  
2 and issuers of individual health benefit plans that are not grandfathered  
3 health plans shall permit providers, policyholders or persons acting on their  
4 behalf to make advance inquiries regarding the appropriateness of a partic-  
5 ular admission to a treatment program. Group health insurers and issuers  
6 of individual health benefit plans that are not grandfathered health plans  
7 shall provide a timely response to such inquiries. Noncontracting providers  
8 must cooperate with these procedures to the same extent as contracting  
9 providers to be eligible for reimbursement.

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

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

26 “(4) The Legislative Assembly finds that health care cost containment is  
27 necessary and intends to encourage health insurance plans designed to  
28 achieve cost containment by ensuring that reimbursement is limited to ap-  
29 propriate utilization under criteria incorporated into the insurance, either  
30 directly or by reference, in accordance with this section.

1 “(5)(a) Any medical necessity, utilization or other clinical review con-  
2 ducted for the diagnosis, prevention or treatment of behavioral health con-  
3 ditions or relating to service intensity, level of care placement, continued  
4 stay or discharge must be based solely on the following:

5 “(A) The current generally accepted standards of care.

6 “(B) For level of care placement decisions, the most recent version of the  
7 levels of care placement criteria developed by the nonprofit professional as-  
8 sociation for the relevant clinical specialty.

9 “(C) For medical necessity, utilization or other clinical review conducted  
10 for the diagnosis, prevention or treatment of behavioral health conditions  
11 that does not involve level of care placement decisions, other criteria and  
12 guidelines may be utilized if such criteria and guidelines are based on the  
13 current generally accepted standards of care including valid, evidence-based  
14 sources and current treatment criteria or practice guidelines developed by  
15 the nonprofit professional association for the relevant clinical specialty.  
16 Such other criteria and guidelines must be made publicly available and made  
17 available to insureds upon request to the extent permitted by copyright laws.

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

21 “(A) Are outside the scope of criteria and guidelines described in para-  
22 graph (a)(B) of this subsection, if the guidelines were developed in accord-  
23 ance with the current generally accepted standards of care; or

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

28 “(c) For all level of care placement decisions, an insurer shall authorize  
29 placement at the level of care consistent with the insured’s score or assess-  
30 ment using the relevant level of care placement criteria and guidelines as

1 specified in paragraph (a)(B) of this subsection. If the level of care indicated  
2 by the criteria and guidelines is not available, the insurer shall authorize the  
3 next higher level of care. If there is disagreement about the appropriate level  
4 of care, the insurer shall provide to the provider of the service the full de-  
5 tails of the insurer's scoring or assessment using the relevant level of care  
6 placement criteria and guidelines specified in paragraph (a)(B) of this sub-  
7 section.

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

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

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

19 “(7) This section does not prevent a group health insurer or issuer of an  
20 individual health benefit plan that is not a grandfathered health plan from  
21 contracting with providers of health care services to furnish services to  
22 policyholders or certificate holders according to ORS 743B.460 or 750.005,  
23 subject to the following conditions:

24 “(a) A group health insurer or issuer of an individual health benefit plan  
25 that is not a grandfathered health plan is not required to contract with all  
26 providers that are eligible for reimbursement under this section.

27 “(b) An insurer or health care service contractor shall, subject to sub-  
28 section (2) of this section, pay benefits toward the covered charges of non-  
29 contracting providers of services for behavioral health treatment. The  
30 insured shall, subject to subsection (2) of this section, have the right to use

1 the services of a noncontracting provider of behavioral health treatment,  
2 whether or not the behavioral health treatment is provided by contracting  
3 or noncontracting providers.

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

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

7 “(B) A long-term residential mental health program that lasts longer than  
8 45 days unless clinically indicated under criteria and guidelines described in  
9 subsection (5) of this section;

10 “(C) Psychoanalysis or psychotherapy received as part of an educational  
11 or training program, regardless of diagnosis or symptoms that may be pres-  
12 ent;

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

14 “(E) Support groups.

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

18 “(9) The Oregon Health Authority shall establish a process for the certi-  
19 fication of an organization described in subsection (1)(j)(G) of this section  
20 that:

21 “(a) Is not otherwise subject to licensing or certification by the authority;  
22 and

23 “(b) Does not contract with the authority, a subcontractor of the author-  
24 ity or a community mental health program.

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

29 “(11) The Oregon Health Authority may adopt by rule an application fee  
30 or a certification fee, or both, to be imposed on any provider organization

1 that applies for certification under subsection (9) of this section. Any fees  
2 collected shall be paid into the Oregon Health Authority Fund established  
3 in ORS 413.101 and shall be used only for carrying out the provisions of  
4 subsection (9) of this section.

5 “(12) The intent of the Legislative Assembly in adopting this section is  
6 to reserve benefits for different types of care to encourage cost effective care  
7 and to ensure continuing access to levels of care most appropriate for the  
8 insured’s condition and progress in accordance with this section. This section  
9 does not prohibit an insurer from requiring a provider organization certified  
10 by the Oregon Health Authority under subsection (9) of this section to meet  
11 the insurer’s credentialing requirements as a condition of entering into a  
12 contract.

13 “(13) The Director of the Department of Consumer and Business Services  
14 and the Oregon Health Authority, after notice and hearing, may adopt rea-  
15 sonable rules not inconsistent with this section that are considered necessary  
16 for the proper administration of this section. The director shall adopt rules  
17 making it a violation of this section for a group health insurer or issuer of  
18 an individual health benefit plan other than a grandfathered health plan to  
19 require providers to bill using a specific billing code or to restrict the re-  
20 imbursement paid for particular billing codes other than on the basis of  
21 medical necessity.

22 “(14) This section does not:

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

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

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

1       **“SECTION 40. The amendments to ORS 414.025, 414.723, 430.637,**  
2       **743A.012 and 743A.168 by sections 35 to 39 of this 2026 Act become op-**  
3       **erative on January 1, 2027.**

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

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