HOUSE AMENDMENTS TO A-ENGROSSED HOUSE BILL 3046

By JOINT COMMITTEE ON WAYS AND MEANS

June 23

On page 1 of the printed A-engrossed bill, delete lines 19 and 20 and insert "in the mental disorders section of the current edition of the:

"(A) International Classification of Disease; or

"(B) Diag".

On page 2, line 1, delete "International Classi-" and delete line 2 and insert ":

"(A) International Classification of Disease; or

"(B)".

On page 3, delete lines 31 and 32 and insert "in the mental disorders section of the current edition of the:

"(A) International Classification of Disease; or

"(B) Diag".

In line 39, delete "International" and delete line 40.

In line 41, delete "of the" and insert ":

"(A) International Classification of Disease; or

"(B)".

Delete line 42.

In line 43, delete "the Oregon Health Authority" and insert:

"(2) No later than March 1 of each calendar year, the Oregon Health Authority shall prescribe the form and manner for each coordinated care organization to report to the authority, on or before June 1 of the calendar year,".

On page 4, delete lines 26 through 45.

On page 5, delete lines 1 through 8 and insert:

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

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

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

"(5) No later than December 31 of each calendar year, the authority shall submit a report to the interim committees of the Legislative Assembly related to mental or behavioral health, in the man-

ner provided in ORS 192.245, that includes:

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

"(b) An assessment of:

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

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

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

"(D) Data on services that are requested but that coordinated care organizations are not required to provide.

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

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

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

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

"(6) Except as provided in subsection (5)(b)(D) of this section, this section does not require coordinated care organizations to report data on services that are not funded on the prioritized list of health services compiled by the Health Evidence Review Commission under ORS 414.690.".

Delete line 42 and insert ", to the extent permitted by the federal Health Insurance Portability and Accountability Act privacy regulations, 45 C.F.R. parts 160 and 164, ORS 192.553 to 192.581 or other state or federal laws limiting the disclosure of health information.".

On page 7, line 28, delete the boldfaced material.

On page 8, line 42, delete "no less frequently than" and insert "in a manner equivalent to the manner in which".

On page 10, line 16, after "shall" insert "provide, at no cost".

Delete lines 17 through 24 and insert:

"(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 medical necessity, utilization or other clinical review criteria and any education or training materials or resources regarding medical necessity, utilization or other clinical review criteria, to the extent permitted by copyright laws.".

On page 13, delete lines 23 through 45 and delete pages 14 through 20.

On page 21, delete lines 1 through 27 and insert:

"**SECTION 7.** Section 2 of this 2021 Act is amended to read:

"**Sec. 2.** (1) As used in this section:

"(a) 'Behavioral health benefits' means insurance coverage of mental health treatment and services and substance use disorder treatment and services.

"(b) 'Carrier' has the meaning given that term in ORS 743B.005.

"(c) 'Geographic region' means the geographic area of the state established by the Department of Consumer and Business Services for the purpose of determining geographic average rates, as defined in ORS 743B.005.

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

"(e) '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.

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

"(A) International Classification of Disease; or

"(B) Diagnostic and Statistical Manual of Mental Disorders.

"(g) 'Nonquantitative treatment limitation' means a limitation that is not expressed numerically but otherwise limits the scope or duration of behavioral health benefits.

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

"(A) International Classification of Disease; or

"(B) Diagnostic and Statistical Manual of Mental Disorders.

"(2) Each carrier that offers an individual or group health benefit plan in this state that provides behavioral health benefits shall conduct an annual analysis of whether the processes, strategies, specific evidentiary standards or other factors the carrier used to design, determine applicability of and apply each nonquantitative treatment limitation to behavioral health benefits within each classification of benefits are comparable to, and are applied no more stringently than, the processes, strategies, specific evidentiary standards or other factors the carrier used to design, determine applicability of and apply each nonquantitative treatment limitation to medical and surgical benefits within the corresponding classification of benefits.

"(3) On or before March 1 of each year, all carriers that offer individual or group health benefit plans in this state that provide behavioral health benefits shall report to the Department of Consumer and Business Services, in the form and manner prescribed by the department, the following information:

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

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

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

"(d) The comparative analyses demonstrating that the processes, strategies, evidentiary stan-

dards and other factors used to apply the nonquantitative treatment limitations to mental health or substance use disorder benefits, as written and in operation, are comparable to, and are applied no more stringently than, the processes, strategies, evidentiary standards and other factors used to apply the nonquantitative treatment limitations to medical or surgical benefits in the benefits classification.

"(e) The specific findings and conclusions reached by the insurer with respect to the health insurance coverage, including any results of the analyses described in paragraphs (a) to (d) of this subsection that indicate that the plan or coverage is or is not in compliance with this section.

"[*(f) The number of denials of behavioral health benefits and medical and surgical benefits, the percentage of denials that were appealed, the percentage of appeals that upheld the denial and the percentage of appeals that overturned the denial.*]

"[*(g) The percentage of claims for behavioral health benefits and medical and surgical benefits that were paid to in-network providers and the percentage of such claims that were paid to out-of-network providers.*]

"[*(h) The median maximum allowable reimbursement rate for each time-based office visit billing code for each behavioral treatment provider type and each medical provider type.*]

"[*(i) The reimbursement rate in each geographic region for a time-based office visit and the percentage of the Medicare rate the reimbursement rate represents, paid to:*]

"[*(A) Psychiatrists.*]

"[*(B) Psychiatric mental health nurse practitioners.*]

"[*(C) Psychologists.*]

"[*(D) Licensed clinical social workers.*]

"[*(E) Licensed professional counselors.*]

"[*(F) Licensed marriage and family therapists.*]

"[*(j) The reimbursement rate in each geographic region for a time-based office visit and the percentage of the Medicare rate the reimbursement rate represents, paid to:*]

"[*(A) Physicians.*]

"[*(B) Physician assistants.*]

"[*(C) Licensed nurse practitioners.*]

"[*(k) The specific findings and conclusions of the carrier under subsection (2) of this section demonstrating compliance with ORS 743A.168 and the Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008 (P.L. 110-343) and rules adopted thereunder.*]

"[*(L)*] **(f)** Other data or information the department deems necessary to assess a carrier's compliance with mental health parity requirements.

"(4) No later than September 15 of each calendar year, the department shall report to the interim committees of the Legislative Assembly related to mental or behavioral health, in the manner provided in ORS 192.245, the information reported under subsection (3) of this section, including the department's overall comparison of carriers' coverage of mental health treatment and services and substance use disorder treatment and services to carriers' coverage of medical or surgical treatments or services.

"**SECTION 8.** ORS 743A.168, as amended by section 5 of this 2021 Act, 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.

"(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; or

"(F) A provider organization certified by the Oregon Health Authority under subsection [*(8)*] **(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 [*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*] **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 [*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*] **criteria and guidelines described in subsection (5) of this section**.

"(k)(A) Subject to the patient or client confidentiality provisions of ORS 40.235 relating to physicians, ORS 40.240 relating to nurse practitioners, ORS 40.230 relating to psychologists, ORS 40.250

and 675.580 relating to licensed clinical social workers and ORS 40.262 relating to licensed professional counselors and licensed marriage and family therapists, a group health insurer 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 approval, concurrent review of the continuation of treatment, post-treatment review or any combination of these. However, if prior approval is required, provision shall be made to allow for payment of urgent or emergency admissions, subject to subsequent review. If prior approval is not required, group health insurers 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) 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.

"[*(5)*] **(6)** To ensure the proper use of 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*] **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 [*medical necessity, utilization or other clinical review criteria*] **criteria and guidelines described in subsection (5) of this section** and any education or training materials or resources regarding [*medical necessity, utilization or other clinical review criteria, to the extent permitted by copyright laws*] **the criteria and guidelines**.

"[*(6)*] **(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.

"[*(7)(a)*] **(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 [*any medical necessity, utilization or other clinical review conducted by the insurer for the diagnosis, prevention or treatment of behavioral health conditions or relating to service intensity, level of care placement, continued stay or discharge*] **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.

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

"[*(9)*] **(10)** The Oregon Health Authority shall adopt by rule standards for the certification provided under subsection [*(8)*] **(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.

"[*(10)*] **(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 [*(8)*] **(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 [*(8)*] **(9)** of this section.

"[*(11)*] **(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 [*(8)*] **(9)** of this section to meet the insurer's credentialing requirements as a condition of entering into a contract.

"[*(12)*] **(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.

"[*(13)*] **(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.".

After line 31, insert:

"**SECTION 10. Notwithstanding any other law limiting expenditures, the limitation on expenditures established by section 1 (6), chapter _____, Oregon Laws 2021 (Enrolled Senate Bill 5510), for the biennium beginning July 1, 2021, as the maximum limit for payment of expenses from fees, moneys or other revenues, including Miscellaneous Receipts, but excluding lottery funds and federal funds, collected or received by the Department of Consumer and Business Services for the Division of Financial Regulation, is increased by $708,708 for the purpose of carrying out the provisions of this 2021 Act.**".