House Bill 3046

Sponsored by Representative NOSSE

SUMMARY

The following summary is not prepared by the sponsors of the measure and is not a part of the body thereof subject to consideration by the Legislative Assembly. It is an editor's brief statement of the essential features of the measure **as introduced.**

Specifies behavioral health treatment that must be provided by coordinated care organizations and covered by group health insurance and individual health plans and restricts utilization review criteria for behavioral health treatment.

A BILL FOR AN ACT

Relating to behavioral health; amending ORS 414.766 and 743A.168.

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

SECTION 1. ORS 414.766 is amended to read:

414.766. **(1)** Notwithstanding ORS 414.065 and 414.690, a coordinated care organization must provide behavioral health services to its members that include but are not limited to all of the following:

[*(1)*] **(a)** For a member who is experiencing a behavioral health crisis:

[*(a)*] **(A)** A behavioral health assessment; and

[*(b)*] **(B)** Services that are medically necessary to transition the member to a lower level of care;

[*(2)*] **(b)** At least the minimum level of services that are medically necessary to treat a member's **underlying** behavioral health condition **rather than a mere amelioration of current symptoms, such as suicidal ideation or psychosis,** as determined in a behavioral health assessment of the member or specified in the member's care plan; [*and*]

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

(d) Treatment at the least intensive and least restrictive level of care that is safe and effective and meets the needs of the individual's condition;

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

(f) Treatment at a higher level of care when there is ambiguity as to the appropriate level of care or when the recommended level of care is not available;

(g) Treatment to maintain functioning or prevent deterioration;

(h) Treatment for an appropriate duration based on the individual's particular needs;

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

[*(3)*] **(j)** Coordinated care and case management as defined by the Department of Consumer and Business Services by rule.

(2) A behavioral health treatment may not be subject to prior authorization except as specifically permitted by the Oregon Health Authority by rule.

SECTION 2. ORS 743A.168 is amended to read:

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

NOTE: Matter in **boldfaced** type in an amended section is new; matter [*italic and bracketed*] is existing law to be omitted. New sections are in **boldfaced** type.

(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 crisis" means a disruption in an [*individual's*] **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 [*individual's*] **insured's** mental or physical health.

[*(c) "Chemical dependency" means the addictive relationship with any drug or alcohol characterized by a physical or psychological relationship, or both, that interferes on a recurring basis with the individual's social, psychological or physical adjustment to common problems. For purposes of this section, "chemical dependency" does not include addiction to, or dependency on, tobacco, tobacco products or foods.*]

(c) "Behavioral health condition" means any condition or disorder that is:

(A) Within any of the diagnostic categories listed in the mental and behavioral chapters of the current edition of the World Health Organization's International Statistical Classification of Diseases and Related Health Problems;

(B) Listed in the current version of the Diagnostic and Statistical Manual of Mental Disorders; or

(C) Commonly understood to be a mental health or substance use disorder by health care providers practicing in the relevant clinical specialties.

(d) "Behavioral health treatment" means treatment of a behavioral health condition.

[*(d)*] **(e)** "Facility" means a corporate or governmental entity or other provider of services for the treatment of [*chemical dependency or for the treatment of mental or nervous conditions*] **behavioral health conditions**.

[*(e)*] **(f)** "Group health insurer" means an insurer, a health maintenance organization or a health care service contractor.

(g) "Medically necessary" means clinically appropriate in the type, frequency, extent, siting and duration, based on generally accepted standards of care, to prevent, screen for, diagnose or manage an illness, injury or condition, including by controlling symptoms, maintaining a current level of functioning or preventing deterioration or relapse, at a level of care that is most effective to treat an individual patient's behavioral health condition and any co-occurring conditions.

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

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

[*(h)*] **(j)** "Provider" means:

(A) An individual 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, is otherwise eligible to receive reimbursement for coverage under the policy and is a behavioral health professional or a medical professional licensed or certified in this state;

(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 [*(7)*] **(12)** of this section.

[*(i)*] **(k)** "Utilization review" has the meaning given that term in ORS 743B.001.

(L) "Treatment" means a service, medication, item or other product prescribed or recommended by a treating provider to address a patient's mental health condition or symptoms.

(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 [*for chemical dependency, including alcoholism, and for mental or nervous conditions*] at the same level as, and subject to limitations no more restrictive than, those imposed on coverage or reimbursement of expenses arising from treatment for other medical conditions. The following apply to coverage for [*chemical dependency and for mental or nervous conditions*] **behavioral health treatment**:

(a) The coverage may be made subject to provisions of the policy that apply **equally** to **all** 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; [*and*]

(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 safe and just as effective as treatment at a higher level of service or intensity;

(F) Treatment at a higher level of care when there is ambiguity as to the appropriate level of care or when the recommended level of care is not available;

(G) Treatment to maintain functioning or prevent deterioration;

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

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

[*(C)*] **(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) An insurer 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 medically necessary behavioral treatment to an insured in a geographic area, the insurer shall provide coverage of out-of-network services necessary for the insured to have timely access to medically necessary behavioral health treatment without any additional out-of-pocket costs.

[*(d)*] **(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.

[*(e)*] **(g)** [*If specified in the policy,*] Outpatient coverage **of behavioral health treatment** [*may*] **shall** include follow-up in-home service or outpatient services **if clinically indicated under 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 subsection (5) of this section**.

[*(f)(A)*] **(h)(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.

[*(g)*] **(i)** 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 or utilization review conducted under subsection (2)(h) of this section 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) Standards of care and clinical practice that are generally recognized by health care providers practicing in the relevant clinical specialties such as psychiatry, psychology, clinical social work, addiction medicine and counseling and marriage and family therapy for the diagnosis, prevention and treatment of behavioral health conditions in children, adolescents and adults.

(B) Valid, evidence-based sources such as peer-reviewed scientific studies and medical literature, clinical practice guidelines and recommendations of nonprofit health care provider professional associations, specialty societies, agencies of the federal government and drug labeling approved by the United States Food and Drug Administration.

(b) This subsection does not prevent an insurer from using criteria that:

(A) Are outside the scope of criteria and guidelines described in paragraph (a) of this subsection if the guidelines were developed in accordance with paragraph (a) of this subsection; 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) of this subsection if the guidelines were developed in accordance with paragraph (a) of this subsection.

(6) To ensure the proper use of the criteria described in subsection (5) of this section, an insurer shall:

(a) Sponsor a formal education program by nonprofit clinical specialty associations to educate the insurer's staff and any individuals described in subsection (2)(h) of this section

who conduct reviews.

(b) Make the education program available to other stakeholders, including participating providers and insureds. Participating providers shall not be required to participate in the education program.

(c) Provide, at no cost, the clinical review criteria and any training material or resources to providers and insureds.

(d) Track, identify and analyze how the clinical review criteria are used to certify care, deny care and support the appeals process.

(e) Conduct interrater reliability testing to ensure consistency in utilization review decision-making and medical necessity determinations. This assessment shall cover all aspects of utilization review.

(f) Run interrater reliability reports about how the clinical guidelines are used in conjunction with the utilization review process.

(g) Achieve interrater reliability pass rates of at least 90 percent and, if this threshold is not met, immediately provide for the remediation of poor interrater reliability and interrater reliability testing for all new staff before they can determine medical necessity or conduct utilization review without supervision.

[*(5)*] **(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*] **insureds** 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 [*the*] **behavioral** treatment [*of chemical dependency or mental or nervous conditions*]. The insured shall, subject to subsection (2) of this section, have the right to use the services of a noncontracting provider of services for [*the*] **behavioral health** treatment [*of chemical dependency or mental or nervous conditions*], whether or not the [*services for chemical dependency or mental or nervous conditions are*] **behavioral health treatment is** provided by contracting or noncontracting providers.

[*(6)(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 subsection (5) of this section**;

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

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

(E) Support groups.

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

(9) If an insurer or other individual described in subsection (2)(h) of this section authorizes a behavioral health treatment by a provider, the insurer or other individual may not

rescind or modify the authorization, after the provider delivers the treatment in good faith and pursuant to the authorization, for any reason including but not limited to the subsequent rescission, cancellation or modification of the group health insurance policy or individual health benefit plan or the subsequent determination by the insurer or other individual that the insurer or other individual did not make an accurate determination of the insured's eligibility. This subsection does not expand or alter the coverage under the group health insurance policy or individual health benefit plan.

(10)(a) A group health insurance policy or individual health benefit plan may not contain a provision that reserves to the insurer or other claims administrator the sole authority to determine eligibility for benefits or coverage, to interpret the terms of the group health policy or individual health benefit plan or to provide standards of interpretation or review that are inconsistent with state law if the provision has the effect of conferring discretion on an insurer or claims administrator to determine entitlement to benefits or interpret terms and conditions that could lead a reviewing court to adopt a deferential standard of review.

(b) Paragraph (a) of this subsection does not prohibit a provision that informs an insured that, as part of routine operations, the insurer or individual described in subsection (2)(h) of this section applies the terms and conditions of a group health insurance policy or individual health benefit plan in making determinations regarding eligibility or benefits or in explaining policies, procedures and processes as long as the provision could not give rise to a deferential standard of review by a reviewing court.

(11) An insurer offering a group health insurance policy or individual health benefit plan may not adopt, impose or enforce terms in policies or provider agreements, in writing or in practice, that undermine, alter or conflict with the requirements of this section.

[*(7)*] **(12)** The Oregon Health Authority shall establish a process for the certification of an organization described in subsection [*(1)(h)(F)*] **(1)(g)(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.

[*(8)*] **(13)** The Oregon Health Authority shall adopt by rule standards for the certification provided under subsection [*(7)*] **(12)** of this section to ensure that a certified provider organization offers a distinct and specialized program for the treatment of mental or nervous conditions.

[*(9)*] **(14)** 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 [*(7)*] **(12)** 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 [*(7)*] **(12)** of this section.

[*(10)*] **(15)** 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 [*(7)*] **(12)** of this section to meet the insurer's credentialing requirements as a condition of entering into a contract.

[*(11)*] **(16)** 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.
